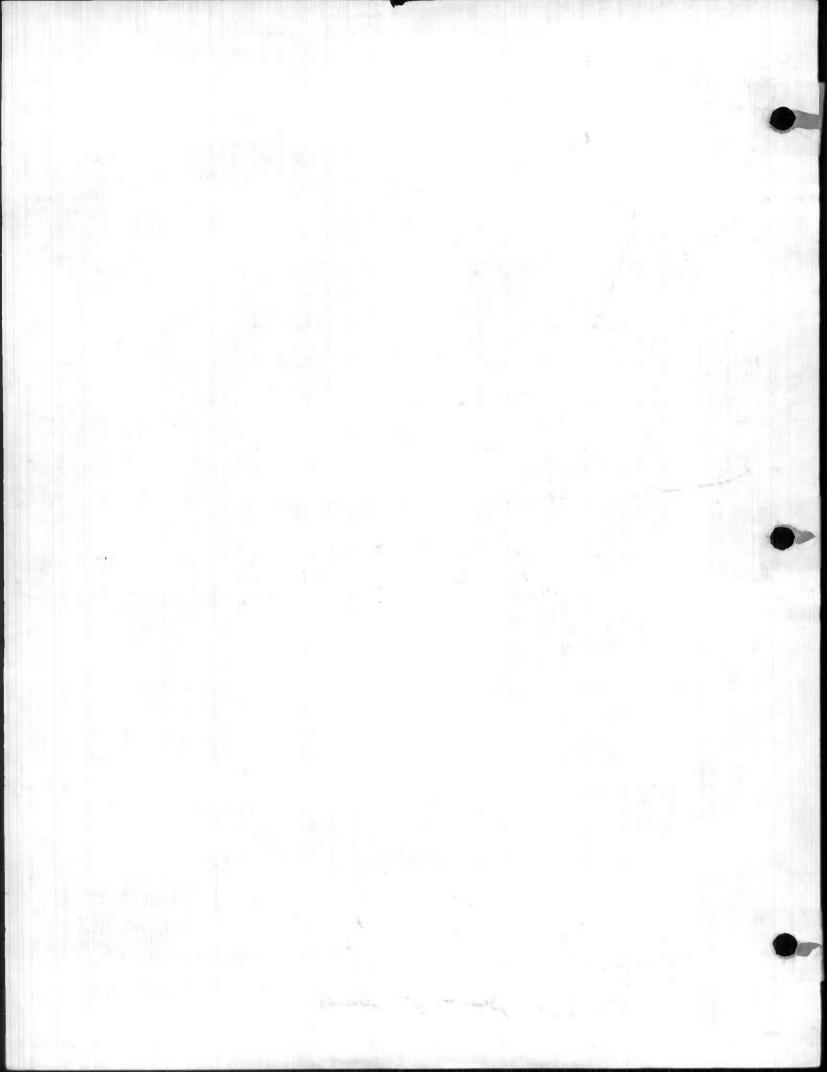
| AMEN | State of Maryland ID#20b PER HSP. GX80 2-16-2000 J.A.B | d / Department of Health and Mer Certificate of Death | ntal Hygiene U 5 U U I |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1 | 1. Decedent's Name (First, Middle, Last) | 2. | Date of Death 3. Time of Death |
| Physician | Patrick Panich | - | Month Day Year ANUARY 12 2000 01:34 Am |
| /Medical | 4a Facility Neme (If not institution, give street and number) | 4b. City, Town, or Locati | |
| Examiner | | Parking | |
| - Comment | 5. Social Security Number 6. Sex, 7. Age (in yrs. la | ast birthday) If Under 1 Year If Under 24 Hrs. 8 | Dete of Birth (Month, Day, Year) Sinthplaca (Stafe or Foreign Country) |
| Funeral Director | TAIDANT 128M 20F | Months Days Hours Min. | (Month, Day, Year) Country) |
| | Usual Rasidence of Decedent | 10 VA | NUARY 12,2000 MARYLAND |
| or 28s-f show be notified at Director | 10a. Stete 10b. County 10c. City | , Town or Location | 10d. Inside City Limits |
| Mary Leaf Land | maniford monto | Arksburg | 1.⊠¥es 2□ No |
| with the Marylar a or 28e-f show be notified at Director | 10e. Street and Number | 10f. Zip Gode | 10g. Citizen of What Country? |
| | 26/30 Frederick ROAD | 20871 | USA |
| har death i rhams 234 sloar must Funeral | 11. Marital Status 12. Was Decedent Ever in U.S | | |
| Fundament of the control of the cont | Armed Forces? 1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No | Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica | an, etc.) Black, Whita, etc. |
| 020 020 020 020 020 | 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yas 2.⊠No Specily: | Specify: () h + e |
| | 15. Decedent's Education | 16a. Decedent's Usuel Occupation | 16b. Kind of Business/Industry |
| 1 21215-0 ed within 72 ho sypiene. Ner than "natur It, the Medical Completed | (Specify only highest grade completed) | (Give kind of work done during most of working life. DO NOT use ratired) | |
| 2121 d within piene. r than r the Med | Elementery/Secondery (0-12) College (1-4or 5+) | INFANT | INFANT |
| d High | 17. Father's Neme (First, Middle, Last) | | irst, Middle, Maiden Sumame) |
| land land land land land land land land | Thomas JAY Panichas | Tracey 1 | 1 Day walda |
| Maryland 42 should be file h and Mental Hy 7 is marked oth treumatic event | 19a. Informent's Neme/Relationship (Type, Print) | 19b. Meiling Address (Street and Number or Rural Re | L. Keynolds |
| Mad 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 s a d 2 | | - | |
| e, N | 20e. Method of Disposition 20b. Pl | ace of Disposition (Name of | Date 20c. Location - City or Town, State |
| O 85 # 5 | 1 Burial 2 Cremetion 3 Removal from Stata | metery, cremetory or other place) | |
| altimore, mil. Pages 1 as partment of Hea portent: If Hear. y Injury or othe ca. | 4 Donetion 5 Other (Specify) | TOTY GROVE /TOVENTIST; | RECKVITE WARNIANA |
| Sall Market | 21. Signeture of Funeral Service Licensee | 22. Name end Addrass of Facility | 901 Medical Conter Drive |
| m 20238 | iloeases Horwood | Shady George Advant | Rockville, and 20850 |
| | 23a. Pert1. Enter the disease, or complications that caused the deeth. | . Do not enjer the mode of gring, such as cardiac or re | apprintory arrest. Approximete |
| Physician | shock, or heart failure. List only one cause on each line. | / . / | Interval Between Onset and Deeth |
| /Medical | Immediate Cause (Final | Her tu | |
| Examiner | disease or condition resulting in death) | 1-00/ | |
| je | 7-80 | 21 | |
| 60, the executed sician and burial-transit | b. John for | as a consequence of): | |
| exec n an ial-tri | Sequentielly list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury | 33 (4) | |
| 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | Cause (Disease or Injury | V | |
| 687 ifficate g phys as the | resulting in death) Last | as a consequence of): | |
| X Sertif | d | | |
| P.O. Box 68 at the death certifical at the death certifical to the attending phystached for use as the Physician/Medi | | | |
| that the dended by the add by Physical y Physical | Pert II. Other aignificant conditions contributing to death but not result | Iting in tha underlying cause given in Pert i. | 23b. Did tobacco use contribute to the cause of death |
| P.O. do by the letache | | | 1 Yes 2 No 3 Probably 4 Unknow |
| S, es tr | | | |
| cord require been si should | | | 24a, Was an autopsy performed? 24b. Were autopsy findings available prior to |
| Of Vital Records, Physician: The lew requires the certificate has been signed in director, page 2 should be call or to be Completed by: | | | completion of cause of death? |
| I Be la | | | 1 Yas 2 No 1 Yes 2 No |
| /ital | 25. Was case referred to medicat | 26. Place of Deeth (C | |
| of Vita hysician: his certific al director, To Be | axaminer? 1 Yes 22 No Hospitel: 12 Inpatient 2 E | Othor | 5 ☐ Residence 6 ☐ Other (Specify) |
| Phy Phy Pr. T. T. T. T. | | | Describe how injury occurred |
| On O ding Ph After th funeral | 7 | Injury Work? M 1 ☐ Yes 2 ☐ No | |
| Division of attending P as after death. al Director: After ted in by the funers Certification: | 3 Suicide 6 Could not be | | Location (Street and Number or Rural Route Number, |
| or A properties in the properties of the propert | 4 Homicide determined 288. Pleas of injury - At not building, etc. (Specify, | | City or Town, State) |
| O See See | | | |
| Ne Hospi n 24 hou Ne Funer pletely fil | (Check only 2 Medical Examiner: On the basis of examineti | viedge, deeth occurred et the time, date and place, and on and/or investigation, in my opinion, death occurred a | due to the cause(s) end menner as stated. at the time, date end place, and due to the cause(s) |
| | one) and menner stated. | | |
| To the Com | 29b. Signeture and title of penilliar | 29c. License number 30660 23a) (Type, Print) Medical Genter Dr. Roc ure B. | 29d. Date signed (Month, Day, Year) |
| | 1 3/20 | 2 30660 | 1/12/00 |
| 10 | 30. Name and address of person who completed cause of deeth (Item | 23a) (Type, Print) | 11/ |
| | Stephen LAKNER 9901. | medical Contactor Do Pos | kuille me Jo85- |
| State | 31. Dete filed Month, Day, Year) FEB 1 7 2000 32. Projetrar's Signature | ure M | 1114 .000 |
| Registrar | FEB 1 7 2000 | h. 1 | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death February 15, 2000 Jennie Ann Robey 1:10PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1315 Chesaco Avenue, Apt 231 Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax 7. Age (In yrs. lest birthday) 1□M 200 F Months Yrs. 90 220-32-3205 2, 1910 Maryland Usuel Residence of Decedant 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 Chesaco Avenue, Apt 231 21237 U. S. A. 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Grade Medical Technician Medical 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Molly Callahan George Goodman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy V. Alphenaar (Daughter) 6838 Shadow Ridge Place, Altaloma, California 91701 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Crametion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park 2/16/00 Baltimore, Maryland 22. Name and Address of Fecility Schimunek Funeral Home Inc. 21. Signeture of Funeral Bervice License 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the diseasa, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or haart failure. List only one cause on each line. Immediete Ceuse (Finel disaasa or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Dua to (or es e consequence of): Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? Osteo Porolis 1 Yes 2 No 1 Yes 20 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

a notified at

Examiner must be Barra 23s

8

'natural', or

Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is merked of

altimore. Maryland 21215-0020

Director

Be

2

physician and s tha burial-transit Box 68760, P.O. 1 signed by the Records, Division of Vital

Examiner Physician/Medical þ Completed Be Medical Certification: To

dospital or Attending Physician: The A hours after death.

"uneral Director: After this certificate by filled in by the funeral director, pa To the Hospital or Within 24 hours aft To the Funeral DI completely filled in

> State Registrar

UJWALA

5 Pending

investigetion

6 Could not be determined

esa

114 m A A

28e. Dete of Injury (Month, Day Year)

29c. Licensa number D 48105

1 ☐ Yas 2 ☐ No

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

UTWALA DESA 3400, E

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

INTERNIST

3400, Brehms Ln, Balt. MD-21213.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

31. Dete filed (Month, Dey, Year)

29b. Signature and title of certifier

27. Menner of Death

Neturel

2 Accident

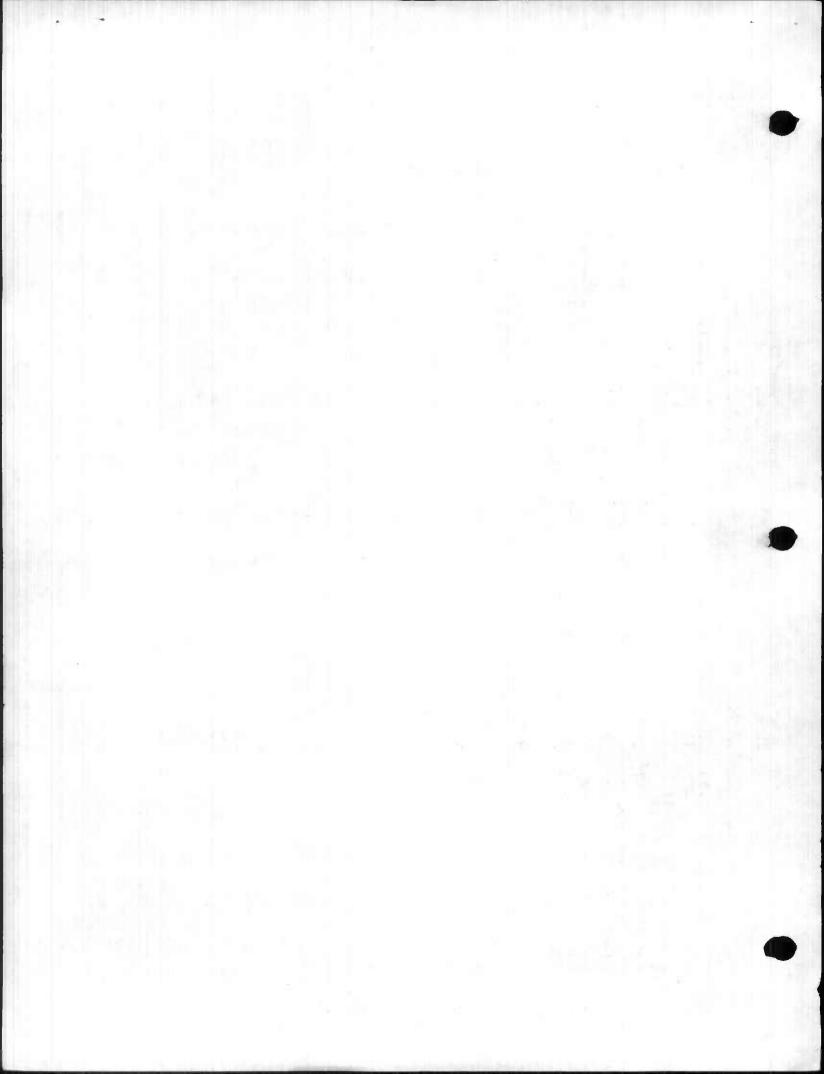
4 Homlcide

3 Suicide

29e, Certifier (Check only one)

FEB 18

32. Registrar's Signeture Jacks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#5 PER INFMT. G780 2-23-2000 JAB Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** Thomas Exter Robinson Sr. 02 14 2000 2:26pm /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Funder 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5419 The Alameda If Under 1 Year 5. Social Security Number 215-10-0552 7. Age (In vrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months XXM 20 F Director V.A the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director 1 Ves 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5419 The Alameda U.S.A.

14. Rece - American Indian, death Funeral 2 1 2 3 9

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2000 Specify: P 3 ₩ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Sanitation Dept. permit. Pages 1 end 2 should be filled wi Department of Health and Mental Hygien Important: If tem 27 is marked other thy any injury or other traumatic event, the DOCS. 9th grade Driver Baltimore City 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First Middle Meiden Sumame) 8 James Wyatt Hattie Patricia Jane Lightfoot 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5419 The Alameda, Baltimore Md 21239 Audrey Robinson-Daughter 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete Quriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2-19-00 Randallstown, Md King Memorial Park 21. Signature of Fureral Service Licensee 22. Neme end Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or es a conse certificate be executed and Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the burle Physician/Medical Due to (or es e consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t Yea 2 No 3 Probably 4 Unknown Records, þ been significant 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 2 No 1 Yas 20 No certificate Division of Vital Hospital or Attending Physician: 24 hours effer death. director 8 25. Wes case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of order death.

N Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide within 24 hours eft To the Funeral Dis completely tilled In 13 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

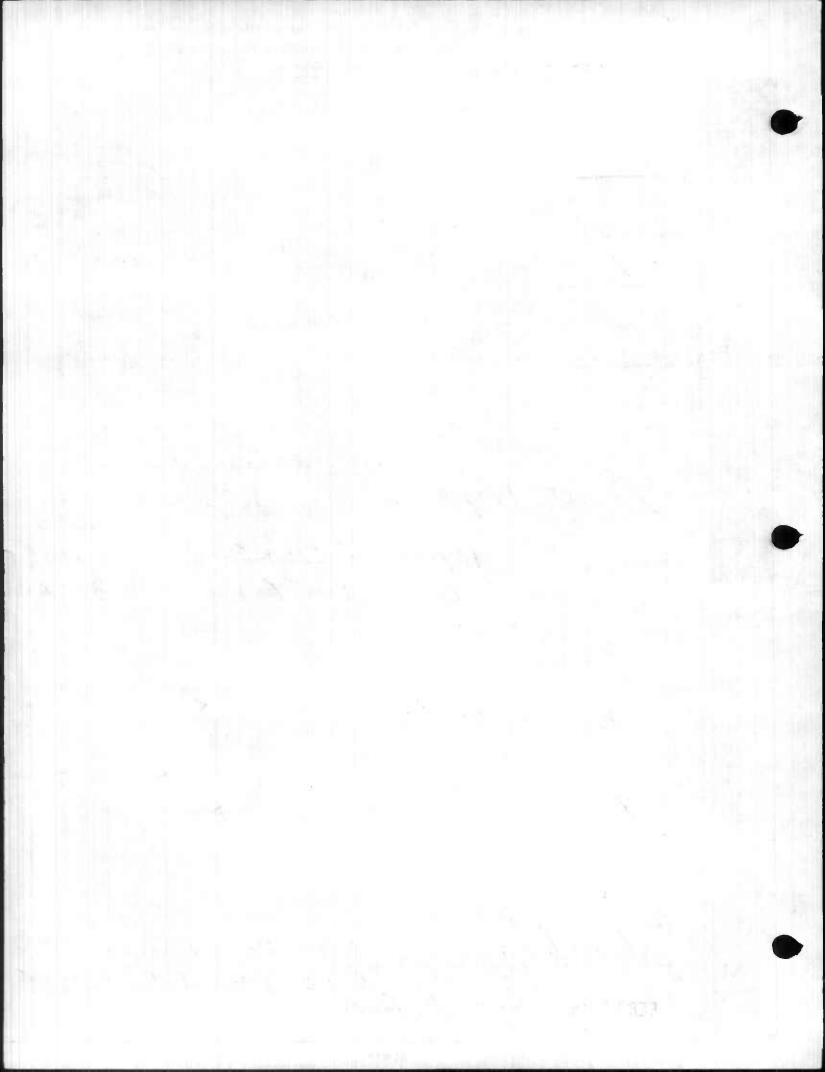
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier To the Fune completely t (Check only one) 4 29b. Signature and title of certifi 29c. License numbe 29d. Dete signed (Month, Day, Year) 30. Name and add use of person who completed cause of death (Item 23a) (Type, Print) KR3 35 31. Date filed (Month, Dey, Year) FEB 1 8 2000

Registrar **DHMH 16 Ray 6/95**

State

racks

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Feb 1245194 Yesi Ericia 15 00 4e Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death dum bia Hospita 100 -end If Under 24 Hrs. H Under 1 Year 5. Social Security Number 6. Gex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 F 213-28-9659 Yrs. 68 May 27, 1931 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. Stete 10d. fnside City Limits MD. Howard Columbia 1 ☐ Yes 2 XNo 10e Street and Number 10f. Zin Code 10a. Citizen of What Country? 10802 Green View Way 21044 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, atc. 1 ☐ Yes 2 No If Yas, Give 1 Never Merried 2 Married 1 Yes 2√2 No Specify: Specify: white 3€ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) credit union manager 12 credit union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Louis A. Kelly Mary Alice Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kelly daughter 10802 Green View Way, Columbia, Md. 21044 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burlat 2 Cremetion 3 Removal from State Baltimore/Wash. Crematory 2/18/00 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licensee 22. Name and Address of Facility Witzke Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21045 Approximate Intervet Between Onset and Death Immediete Cause (Finat disease or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Part ff. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contributa to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Hyporia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturat 5 Pending investigation 1 Yes 2 No

buriel-transit Box 68760, The law requires that the death certificate be use as the P.O. | Records. Division of Vital or Attending Physician: this Affer the f

Completed by Physician/Medical Examiner Be Certification: To filled in by

Physician

/Medical

Examiner

Director

Funeral

à

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Funeral

Director

28a-f

23a or

Barnes :

permit. Pages 1 and 2 should be flied within 72 hours after Department of Health and Mental Hyglens. Insportant: it less 27 is marked other than "natural", or the any Injury or other traumatic awant the Manifest F

Physician

/Medical Examiner

Saltimore, Maryland 21215-0020

death with the Maryland

within 24 hours after death. To the Funeral Director: Al edical completely Registrar

State

De Ceva

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signeture end tale of certifie

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

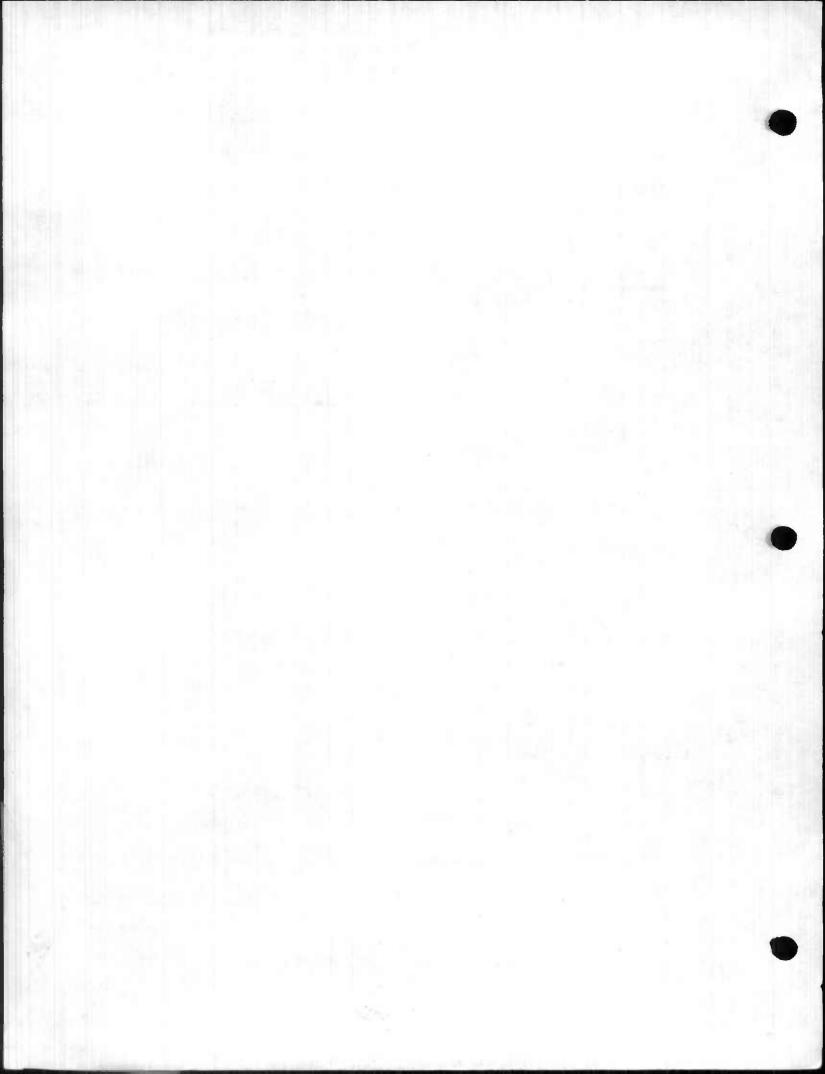
28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Dey, Year) 32. Registrer's Signeture FEB 1 8 2000

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Ray 6/95

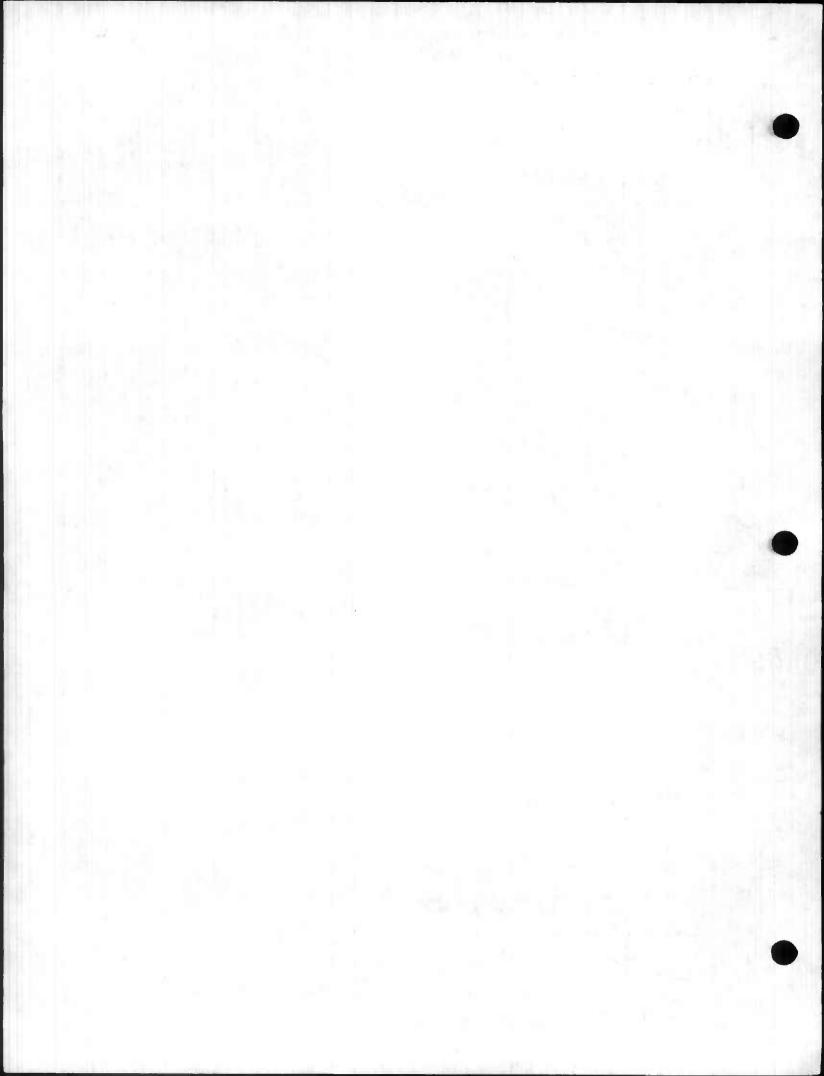
To the Hospital



| Amende | d_I | tem # 10d,pe | | | 00,gap | Cei | rtificate of | Death | | g. No. | | 0 Time -4 P |
|-------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------|----------------------------------------------|-----------------------------------------|------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------|----------------------------------|--------------------------------------|------------------------------------------------------------------------|
| Physicia | | 1. Decedent's Name TILLIE | (r-irst, Midd | a, Last) | | ROSENBERO | 3 | | 2. Data of Deat Month FEB. 15 | 2000 | Yaar | 3. Time of Death 11:05AM |
| /Medic Examin | | 4a Facility Nama (If | not institutio | n, giva street and n | | | | 4b. City, Town, or I | 1 | 4c. County | of Death | |
| | | MILFORD M | IANOR I | NURSING H | OME | | | BALTIMORI | | BALTI | MORE | |
| neral ector | | 5. Social Security Nu 2195660 | 62 | 6. Sex 1 □ M XXF | 7. Age (h | 97 Yrs. | If Undar 1 Yeer Months Days | If Undar 24 Hrs. Hours Min. | 8. Deta of Birth | 1902 | 9. Birthpla POLAI | ace (Stata or Foraign |
| ** | | Usual Rasidanca of I 10a. Stata | Decedent 10b. County | | 10 | oc. City, Town or Lo | ocation | | | | 10 | d. Inside City Limits |
| ner must be notified at | tor | MD | BALTI | MORE | | ANDALLSTO | | | | | - | Yes 2 NO |
| TOU. | Director | 10e. Street and Num | ber | | | | 10f. Zip Code | | 11 | Og. Citizan of V | What Count | ry? |
| | | 3503 BEAG | LE LA | NE # 104 | | | 2113 | 3 | | USA | | |
| | by Funeral | 11. Marifal Status 1 Nevar Merrie 3 Widowed 4 | ed 2 Mer | 12. Was De Armed F ried 1 ☐ Yas If Yas. G | Forcas? 2 No Siva | | Wes Decedant of I If Yes, specify Cub 1 ☐ Yas 2 ☑ No | dispante Origin? (S an, Maxican, Puart Specify: | pecify Yes or No- o Rican, etc.) | Bled | a - America ck, Whita, a WHITE | |
| | pete | | | nt's Education st grada completed | 0 | 16a, Dece | dant's Usual Occup | pation during most of wor | | 16b. Kind of Bu | usinass/Indu | ustry |
| | Completed | Elementary/Secon | | 1 | (1-4or 5+) | lifa. | DO NOT usa retire | d) | | | | |
| | | 17. Fathar's Name (/ | First Middle | (act) | | HOMEMA | AKER | 19 Mothar's Nes | me (First, Middle, M | WN HOM | | |
| | 9 Be | MAURICE | rrst, moore, | | SENBE | RG | | SARAH | ne (r irst, milotie, n | | NBERG | |
| | To. | 19a. Informant's Nar | me/Relations | | | | ng Addrass (Street | and Number or Ru | ıral Route Number | City or Town, | Stata, Zip | Code) |
| | | ELAINE DOU | JGLAS/ | DAUGHTER | | 3601 | CLARKS I | ANE APT. | 514 BALT | IMORE, | MD. | 21215 |
| | | 20e. Mathod of Dispo 1 Donation | Crametion | 3 □Ramoval from | n Stata | WORKMAN | psition (Nama of matory or other pla IRCLE | ca) | 2/17/2000 | 20c. Location - DUNDA | | |
| BUCB | | 21. Signature of Fun | H Service | The a | alle | / | 2. Nama and Address | ass of Fecility SO: ERSTOWN | L LEVINSO | | | |
| n il er | 7 | 23a. Part1. Enter the shock, or heart Immediata Causa (F disease or condition rasulting in death) | t failura. List Final | r complications that I only ona causa on a | aach lina. | Chewic Late (or as a consec | Cald | OMUPPO | thy | | | Approximate Interval Between Onset end Deeth |
| | an/Medical Examiner | Sequantially list con if any, laading to imreause. Entar Undar Cause (Diseasa or it that initiated events rasulting In daath) Li | njury | b | | a to (or as a consec | | (2) |)4>6\9\ar | Diseas | se s | y gors |
| | Physician/M | Part ff. Other signific | cent conditie | ons contributing to | death but n | ot rasulting in tha u | indarlying causa gi | van in Part I. | 23b. Did to | / | | the cause of death |
| | Completed by | | | | | | | | 24a. Was a perform | | eva | ra autopsy findings ilabla prior to applation of cause leath? |
| | | | | | | | | | 1 🗆 Y | as 2 No | 1□ | Yas 2□ No |
| | o Be | 25. Was case ratarre axaminer? | | Hospital | 11 | • 🗆 = = = = = = = = = = = = = = = = = = | Ot Ot | har: | ath (Check only on | | | |
| | \vdash | 1 ☐ Yes 2 ☐ ↑ | | 28a. Data | Inpatiant a of Injury | 2 ER/Outpatie | nt 3LI DOA | 4 LY Nursing F | loma 5 ☐ Reside | | | 7) |
| | ation | 1 Natural 2 Accident | 5 Pendii invasti | ng (Mo | onth, Day Ye | sar) Injury | | rk?]Yas 2∐No | | | | |
| | Certification: | 3 ☐ Suicida 4 ☐ Homicida | 6 Could determ | nined 259. Plac | ce of tnjury ding, atc. (5 | - At home, farm, st Specify) | reat, factory, office | | 28f. Location (SI City or Town | reet and Numb n, Stata) | ber or Rural | Routa Number, |
| | edicai | 29a. Certifier (Check only one) | 1 Certifyir 2 Medical | ng Physician: To the Examiner: On the and ma | na best of m basis of axi annar stated | amination and/or in | h occurred at tha ti vestigation, in my | me, data and place opinion, death occu | e, and due to tha curred at the tima, d | ausa(s) and ma ate and place, | annar as sta and due to | ated. the cause(s) |
| | M | 29b. Signatura and f | itla of partific | Tw (opa | QD | M | 29c. Lican | L7034 | 2 | ed. Data signa | d (Month, L | 6, 2000 |
| | | Tra Hunt | . (| who completed car | Ea. | (Item 23a) (Type, | Print) | Randalle | town My | 211 | 22) | , |
| Stat | | 31. Date filed (Month | - 0- | 71.00 | Registrar's | 101 | | N | 1,000 | 2 | | |

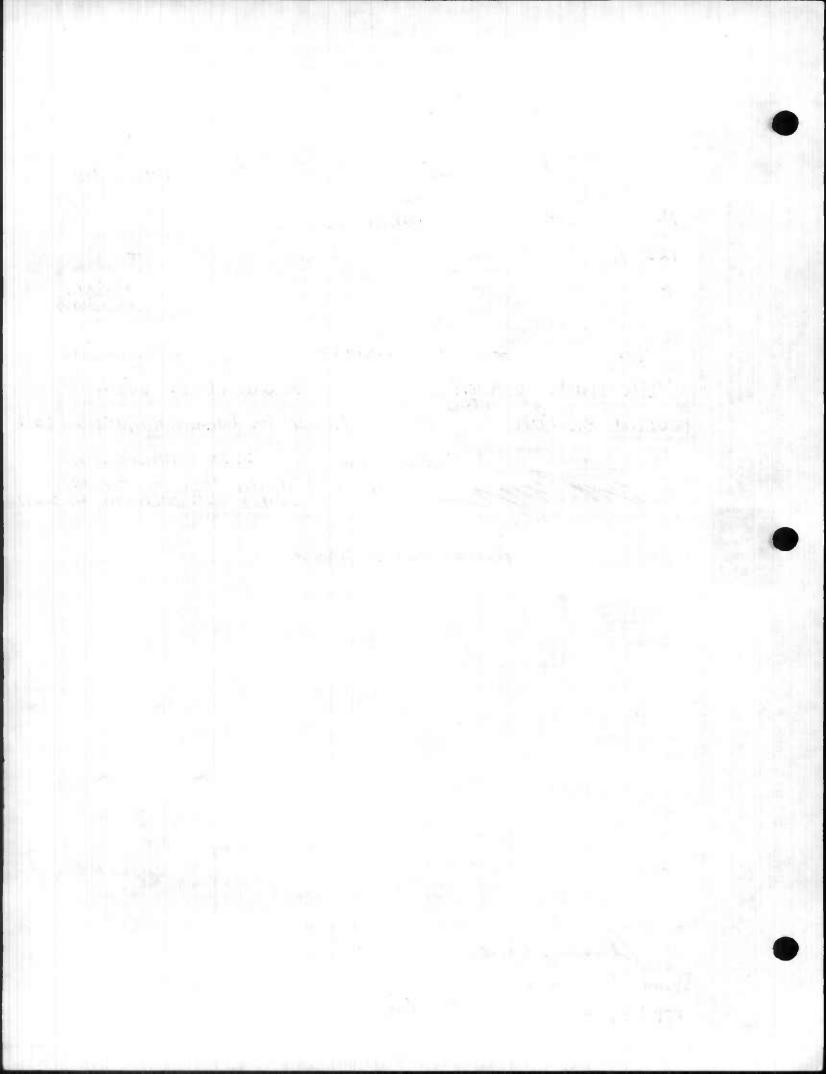
DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 6

| | | | | | | | Certifica | ate of | Death | | Reg. No. | | 0000 |
|------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------|-----------------------|-----------------------------------------------|--------------------------|---------------------------------------|-------------------------------------------|-----------------------------------------|-------------------|------------------------------------------|
| | | | 1. Decedent's Name (Fit | rst, Middle, La | st) | | | | | 2. Date of D Month | | Vasa | 3. Time of Death |
| | Physic /Medi | | anthon | 14 DE | onto S | mith |) | | | FEBRU | Day ARV 16 | 2000 | 1156 AM |
| | Exami | | 4a Facility Name (If not | | e street and number |) | | | 4b. City, Town, o | or Location of Dea | | | TIJU AN |
| 1 | | | UNIVERSIT | Y HOSPI | TAL | | | | BALTIMO | RE CITY | N | A | |
| Г | Funeral | | 5. Social Security Number | eruk 6. S | | ge (In yrs. las | Month | der 1 Year Days | | rs. 8. Date of B (Month, D | irth wy, Year) | 9. Birtho Coun | lace (State or Foreign try) |
| | Director | | Usual Residence of Dec | edent | | 20 | 17/4 | 1 | | June 3 | 20, 19 14 | | HD |
| | Du Maria | | | . County | | 10c. City, | Town or Location | | | | | 1 | Od. Inside City Limits |
| | Very de la | 0 | MD | NI | 4 | | Baltin | 20.00 | 1 | | | | 1 Yas 2 No |
| | 100 to | Director | 10e. Street and Number | 1 17 | - | | | Zip Code | | | 10g. Citizen of V | What Coun | trv? |
| | with a | ō | | | L | 1 (- | | 2 | 1217 | | I V | 1 | |
| | 53 | 978 | 122 N. | MOL | 12. Was Deceden | reet | , 12 Wes D | OL I | 1217 | (Cassity Van as N | 05 | e - Americ | en Indian |
| | flams ner m | Funeral | 11. Marital Status | | Armed Forces | ? | If Yes, s | pecify Cub | an, Mexican, Pu | (Specify Yes or Nerto Rican, etc.) | Blac | k, White, | |
| 020 | 5 6 | by F | 178 Never Married 3 Widowed 4 | | 1 Yes 25 If Yes, Give Year or Dates | | 1 🗆 Yes | 2/No | Specify: | | Specify | age | ican |
| 21215-0020 | n 72 hours "natural", | | 15. | Decedent's Ed | ducation | | 16a. Decedent's U | sual Occup | pation | | 16b. Kind of Bu | usiness/Inc | Justry |
| 215 | nin 7 | Completed | (Specify or Elementary/Secondary | | (College /1-4or | 54) | (Give kind of life, DO NO) | work done Tuse retire | during most of w d) | vorking | | | |
| 21 | ill Hygiene. other then | E | 1146 | / (0-12) | College (1-4or | 3+) | La | bor | | | Com | mer | cial |
| | Hyding Hyding | Be C | 17. Father's Name (First | , Middle, Last) | | | | | | ame (First, Middl | | | |
| 8 | Mental Mental arked c | To B | Master 1 | 1/0/26/0 | o andle | M | | | RN | palind | . , 5 | mitt | 3 |
| Maryland | s 1 and 2 should be filed within if Health and Mental Hygiens. Item 27 is marked other than other traumatic avent, tha M | | 19a. Informent's Neme/ | Relationship (| | 011 | 19b. Mailing Addre | ess (Street | | | ber, City or Town, | State, Zip | Code) |
| Ξ | and 2 selth a n 27 is or train | | Rossind. | N. Sn | rith | ~ | 505 N. | Mr | cher s | St. Bals | 4 mores 1 | mac | illand 21217 |
| 6 | ges 1 and t of Health if Nam 27 or other tr | | 20a. Method of Dispositi | on | auc | 20b. Plac | ce of Disposition (f | Vame of | 314 | Date | 20c. Location - | City or To | n, Stete |
| Baltimore | 20- 2 | | | | Removat from State | | netery, crematory of | r other pla | ce) | 1 2/20/100 | antono | 441 | |
| 量 | | | 4 Donation 5 21. Signature of Funeral | | | MES | TERN ST | AR | ssed Facility | 12/22/00 | Carory | wille | S, 40 |
| Ba | Departir Moorts any Inju | | 21. Signature of Puneral | gervice Cicer | 1111 | | alb | 087 | Pall | uli, 4 | uneral | Am | LAA |
| | 40144 | | 190 | | WILL | | 638 | N. | Sul | noi 5 | t. Buch | more | MD 21217 |
| | | | 23a. Part1. Enter the di- shock, or heart fail | ure. List only | plications that cause one cause on each | d the death. line. | Do not enter the m | ode of dyi | ng, such as card | liac or respiratory | arrest, | | Approximate Interval Between |
| | Physician | | | | | | | | | | | 1 | Onset and Death |
| 10 | /Medical | | Immediate Cause (Final disease or condition | Í | · Mul | tiple | Gunshot | Ub | unds | | | 1 | |
| | Examiner | | resulting in death) | | 8 | Due to (or a | is a consequence | of): | 7770 | | | | |
| | D # | ē | | | | | | | | | | i | |
| | floate be executed g physician and as the burlat-transit | Examiner | Sequentially list condition | ons, | D | Due to (or a | s a consequence o | of): | | | | | |
| 0 | e uni | | Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury) | iate | | | | | | | | i | |
| 68760, | nysic he b | Ca | that initiated events resulting in death) Last | 5 | C | Due to (or a | s a consequence o | f): | | | | | |
| 99 | E 6. | Medical | resoning in dealify case | | | | | | | | | 1 | |
| Box | attandii for use | | | | d | | | | | | | 1 | |
| | the atte | Physician/ | Part II. Other significant | conditions o | ontributing to death | but not resulti | ing in the underlyin | g cause gir | ven in Part I. | 23b. Die | I tobacco use co | ntribute to | the cause of death? |
| P.0 | that the dead by the detached | Å. | | | | | | | | 10 | Yes 2000 | 3 Prol | bebly 4 Unknown |
| | at ped | by | | | | | | | | | | | |
| Records, | - 00 173 | | | | | | | | | | s an autopsy formed? | 24b. W | ere autopsy findings allable prior to |
| 8 | | 5 | | | | | | | | _ par | omeur | CO | mpletion of cause death? |
| æ | | Completed | | | | | | | | . 0 | Kes 2□No | | |
| VItal | denificate | | OF Was seen minus to | a made at | | | | | 71 27 - 12 | | | | Yes 2□ No |
| ₹ | entific rector, | o Be | 25. Was case referred to axaminer? | medical | Hospitel: | | | . Ott | hoe | Deeth (Check only | | | |
| ō | Physician: this certific | - | 17 Yes 2 No 27. Manner of Death | | 1 ☐ Inpat | | ₹/Outpatient 3☐ 8b. Time of | UUA | 4 LI Nursing | Home 5 Res | idence 6 LJOth how injury occur | | y) |
| | Affar funer | <u>o</u> | 1 Natural 5 (| Pending | (Month, D | ay Year) | Injury | 28c. Inju Wo | | /- | -1 -2 4 | 100 | |
| 100 | Attending or death. ector: After by the fune | Cal | 2 ☐ Accident 3 ☐ Suicide 6 | investigation Could not be | | | | | Yes 2 No | Subje | (Street and Numb | D | I Parto Number |
| Division | XETE | Certification: | 4 SHomicide | determined | 289. PIBCB OF IT | itc. (Specify) | e, farm, street, fect | ory, office | | Gity or To | own, State) | Bleck 1 | N. Care St |
| _ | 10 2 2 E | | | | | 'ar an | street | | | Path, | nove, My | | / |
| | Fund Fund Staly | edical | 29e, Cartifier (Check only one) | Medical Exam | ysician: To the best niner: On the basis | of examinetion | edge, death occurrent n and/or investigati | on, in my o | me, date and pla opinion, deeth oc | ice, and due to the corred at the time | e cause(s) and ma e, date and place, | and due to | lated. the cause(s) |
| | To the Hospital of Within 24 hours a To the Funeral D completaly filled | Me | 29b. Signature and title of | | and manner s | ta(90. | | 29c. Licens | | | 29d. Date signe | | |
| | F 3 F 8 | | | - Section | 101 | , | 1 | | | | FEBRUARY | | |
| | | | Wer | mi | & Church | 10 | | 1,701 | | | LIDINOARI | ±/, | 2000 |
| | 0 | | 30. Name and address o | f person who | completed cause of | death (Item 2 | 3a) (Type, Print) | | | | | | |
| | | | Vennis J. | Chute | e, mo 1: | ll Penr | Street, | Bal | timore. | Maryland | 21201 | | |
| | Sta | _ | 31. Data filed (Month, Da | | 32. Regist | rar's Signatur | · las | 7.4. | | 7 | | | |
| | Regist | ar | FEB 1 8 20 | 00 | Denur | 10 | poort | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month **Physician** 15 FEBTUATY 015 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner NA Saltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number 9. Birthplece (Stata or Foraign Country), **Funeral** Days Months 205-28-4139 Usuel Residence of Decedent 1 M 2 F Director 10a. Stete 10b. County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Baltemore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a or 2503 21215 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Meritel Stetus 14. Race - American Indien. Bleck, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If hem 27 is marked other than "natural", or flex any injury or other traumatic event african 1 Never Merried 2 Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: ģ 3 Widowed 4 Divorced american Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Kethred haboru 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Roosevelt Fretha Brow Lennon 19a. Informant's Name/Reletionship (Type, Print) 5an 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Edgewood, MD 21040 *nottuk* 702 20c. Location - City or Town, Stete 20a. Melhod of Disposition

1 Burial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerel Service Licensee and Address of Facilit 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or haert feilure. List only one gentle on each lina. altimore 402121 Approximata tntarval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner physician and the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest Due to (or as a consequence of): Box 68760, PIDEMIC Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Yaa 2□ No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 1 Yas 20 No 1 Yas 2 No or Attending Physician: 25. Was case referred to medicel examinar? Be 26. Place of Death (Check only ona) Hospital: edical Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural
2 Accident 5 Pending investigation death. 1 Yes 2 No Director: / To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by th 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.

Let a the dicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signeture and title of complin 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 16 Ray 6/95

id causa of death (Item 23a) (Type, Print)

NGRV M.D. DEPT

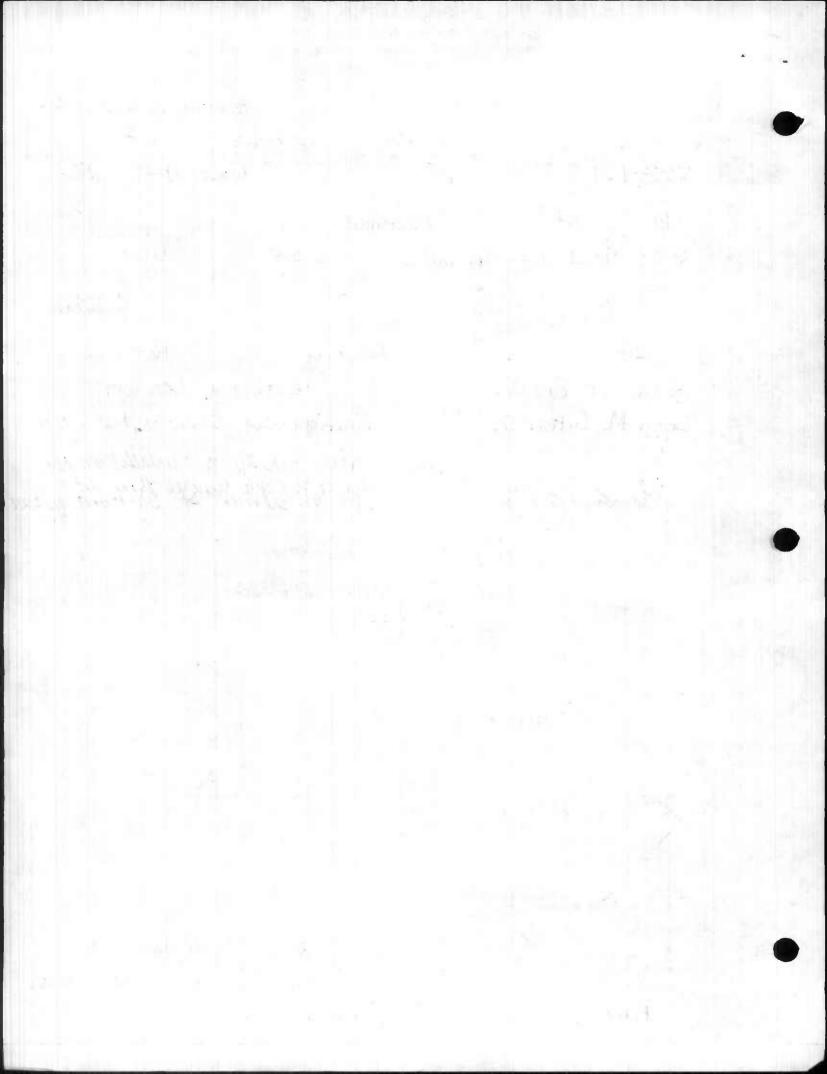
Registrer's Signeture

Aschinger

31. Dete filed (Month, Day, Year)

FEB 18

2000



| 00-0920-025 | ricase Type of Frint in Diask indensit |
|-------------|----------------------------------------|
| CPECOPY | State of Maryland / Department |

| GI | REGORY | | | State of M | | | | | lealth and N | Mental Hy | giene | 10 1 | 05008 |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------|-----------|--------------|-------------------|---------------------------------------------|-------------------------|----------------|----------------------|----------------------------------------|
| S | KILLMAN | | | | | of | Death | 100.10 | Reg. No. | | | | |
| | Physici | an | 1. Decedent's Nema (First, Middle, Las | | | | | | | 2. Data of De Month | Day | Year | 3. Tima of Death |
| ξ, | /Medi | cal | GREGORY ALLAN SK | | -1 | - | | | 4b. City, Town, or L | FEBRUA | | 2000 nty of Death | 1700hrs. |
| 1 | Examir | ner | 4a Facility Nama (If not institution, give 2607 BELAIR ROAD | Street and number | " | | | 1 | FALLST | | | FORD | |
| _ | | | 5. Social Security Number 6. S | ex 7. A | iga (In yrs. last bir | thday) | If Under | 1 Year | If Under 24 Hrs. | 8 Date of Birth 0 B | | | place (State or Foreign |
| | Funeral Director | | | M 2□F 4 | | Yrs. | Months | Days | Hours Min. | Nov. 2 | 7. 1954 | Cou | yland |
| | 2 | | Usual Residence of Decedent | | 1 an Ou W | | | | | | | | |
| | ahora ahora | 7 | 10a. Stata 10b. County | | 10c. City, Tow | | ation | | | | | | 10d. Inside City Limits 1 ☐ Yas 2 ☑ No |
| | Pe M | Director | Maryland Harford | 1 | Joppa | | 10f. Zip (| Codo | | | 10a Citizan | 4 Martines Cons | |
| | with | | | | | | | | | | 10g. Citizen o | | rwry r |
| | 25 E | Funeral | 1001 Hanson Road | 12. Was Deceden | t Ever in U.S. | 13. W | | 0 8 5 ent of H | lispanic Origin? (So | ecify Yes or No | U.S.A | ace - Ameri | can Indian, |
| | her d | FG | 1 Never Married 2 (3 Merned | Armed Forces | ? | | | | lispanic Origin? (Sp an, Mexican, Puerto | Rican, etc.) | 8 | llack, Whita, | |
| 020 | ura a | by | 3 Widowed 4 Divorced | If Yas, Give Year or Datas: | | 1 | ☐ Yas 2 | Ø No | Specify: | | Spec | wh | ite |
| 5-0 | 72 ho | Completed | 15. Decedent's Ed (Specify only highest gra- | ucation de completed) | 16a. | Decede | ent's Usual | Occup | etion during most of work | cina | 16b. Kind of | Business/ir | dustry |
| 2 | ithin | du | Elementary/Secondary (0-12) | College (1-4or | | | | | during most of work d) | | | | |
| 7 | Her to | S | 17. Father's Nama (First, Middle, Last) | 1 year | P | hoto | Lab | Mar | 18. Mother's Nam | a (Firet Middle | | | cessing |
| an | lette p b p b p b | Be C | William A. Skillr | ma n | | | | | Anne C. | | | | |
| Maryland 21215-0020 | about M M mark | To | 19a. Informant's Name/Reletionship (7 | | 19b | . Meiting | Address | (Street | and Number or Rui | | | vn, State, Zi | p Code) |
| Σ | 27 in 27 in 42 | | Patricia A. Mull | igan (Wif | e) 1 | 001 | Hans | on F | Road. Jo | ppa. MD | 2108 | 5 | |
| altimore, | - 1 E E | | 20a. Mathod of Disposition | | 20b. Place of cemeter | Dispos | ition (Nam | e of her plac | 00) | Data | 20c. Locatio | n - City or T | own, State |
| Ĕ | Pega Int: H | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | Green | | | | | 2/17/00 | Balti | more. | Maryland |
| <u>a</u> | permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hyglene. Important: if Itam 27 is marked other than "natural", or Itama 23e or 28e-f show supt figury or other traumatic avent, the Medical Earthing must be notified at once. | | 21. Signature of Funeral Service Licen | 100 | | 22. | Name and | Addre | ss of Facility | | | | |
| m | 2258 | |) ICa | 111 | | 61 | 10 W. | ner Mac | Funeral Phail Ro | ad. Be | l Air. | MD 1 | 21014 |
| | | | 23a. Part1. Entar the disaasa, or comp shock, or heart failura. List only | olicetions that causa | ad tha daath. Do i | not enta | r tha mode | of dyir | ng, such as cardiac | or respiratory a | rrest, | 1 | Approximate Interval Between |
| 5 | Physician | | | 0.0 | 1 1 | | 1 | < | TO. | | | | Onset and Deeth |
| | /Medical Examiner | | Immediata Cause (Final disease or condition resulting in death) | a. IV | lult | TO |) e | - 4 | Lnice | wie | S | | |
| | | 16 | resouring at county | | Dua to (or as a | consed | uence of): | | 7 | | | 1 | |
| | De insit | Examiner | | b | D . A. / | | | | | | | i | |
| 'n | sate be executed shysician and the burlei-transit | Exa | Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | | Dua to (or as a | consequ | sence or): | | | | | | |
| 8760, | ysicia bur | dical | Cause (Disease or injury that initiated events | C | Dua to (or as a o | consequ | ence of): | | | | | | |
| Ø | nd ph | Den | resulting in death) Last | | | , | | | | | | 1 | |
| Box | death certific e attending p ed for use as | Par | | d | | | | | | | | 1 | |
| 0. | the at | Physician/Me | Part It. Other significant conditions co | ontributing to death | but not rasulting is | n the un | derlying ca | use giv | ven in Part I. | 23b. Did | tobacco use | ontributs | to the cause of death |
| <u>.</u> | that the dended by the | Ph | | | | | | | | 10 | Yes 25 N | 3 Pro | obably 4 Unknow |
| ds, | 2 0 0 | d by | | | | | | | | 24s Was | an autopsy | 24h V | Vere autopsy findings |
| ecord | been significant | Completed | | | | | | | | | ormed? | 81 | vailable prior to ompletion of causa |
| ě | | m du | | | | | | | | | / | | death? |
| Vital | n: The ficate h or. page | O O | 25. Was case referred to medical | | | | | | ne Diana di Dan | | Yes 2□No | , 1 | ©Yas 2□ No |
| | Physician: The le this certificate had rai director, page 2 | To B | examiner? | Hospitat: | tient 2 ER/Ou | tnation | 3□ 00 | Oth | 26. Place of Dea | orne 5□ Res | | Other (Snec | SCENE |
| 0 | ar this | | 27. Manner of Death | 28a. Date of In | | Time of | | Bc. Injur | | | how injunyou | | tockehich |
| Ö | Attending ir death. ector: Atta by the fund | atlo | 1 □ Naturat 5 □ Pending investigation | 0/141 | 00 4 | 19 | Ma | | Yes 20 No | Calle | des | itha | nother which |
| Division | i or Attending Phater death. Director: After this in by the funeral | Certification: | 3 Suicide 6 Could not be determined | Sold Lyacon of the | njury - At home, fa ric, (Specify) | ym, stre | et, factory, | office | | 28f Location City or To | (Street and Nu | mber or Ru | ral Route Number |
| | Tei Die | | | Stree | + ; N | or, | Th o | T h | lebers Landingt | 2607 | Bela | irkd | Hallston, M |
| | A Hospital or 24 hours after Punerel Dir lataly filled in | dical | | | of examination an | | | | me, date and placed opinion, death occur | | | | |
| | 4 - 4 - | - A | | IIIwinidi a | | | | | | | | | |

DHMH 16 Rev 6/95

State Registrar

causa of death (Item 23a) (Type, Print)

O.C.M.E.

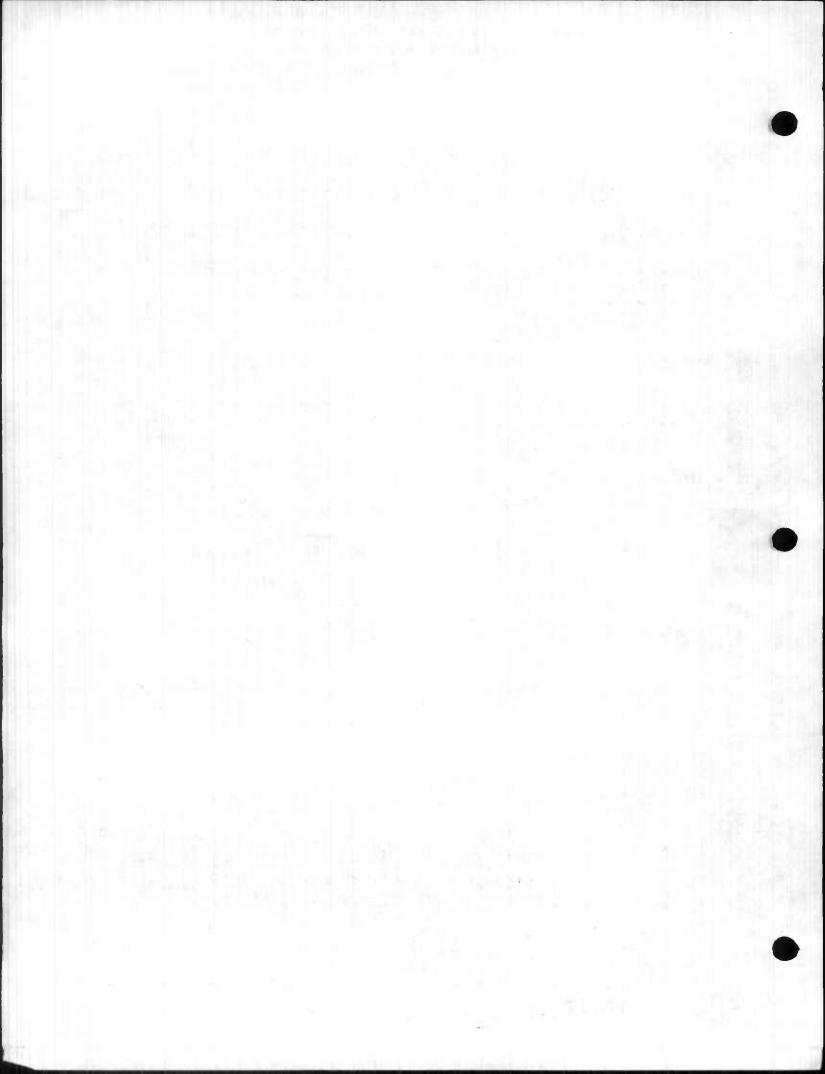
29c. License number

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

FEBRUARY 15,2000

estane



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death February 16, 2000 **Physician** Walter Herman Steger 7:20 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 7, 1907 9. Birthplace (State or Foreign County) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours HOM 2□F 219-32-2347 92 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-I show suy injury or other traumatic event, the Medical Examinat must be notified at each 606s. 10a. State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yas 2 No Md. Carroll Manchester 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 3045 Wood Drive 21102 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give A 1 Yes 2 No Specify: 21215-0020 Specify White P 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Oil & Coal Dealer Fuel aitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Steger Mary Elizabeth Deihl 0 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances L. Steger - Wife 3045 Wood Dr. Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal Irom State Trinity U.C.C. Cem. Feb. 19,2000 Manchester, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel 21. Signature of Funeral Service Lipens co HI 3296 Charmil Dr. Manchester, Md. 21102 intions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. **Physician** Congestive Heart Friland /Medical Immediate Cause (Final 12m0 disease or condition resulting in death) Examiner Examiner The law requires that the desth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. 1 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records, 24b. Were autopsy lindings available prior to Completed 24a. Wes an autopsy completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vitai or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 Rou 1. Mm. MM 032882 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12507 Suzuman For. 1 Cm. Robert 6. Moss 31. Date filed (Month, Day, Year) FEBI 8 2000 32. Registrar'a Signature State

DHMH 16 Ray 6/95

Registrar

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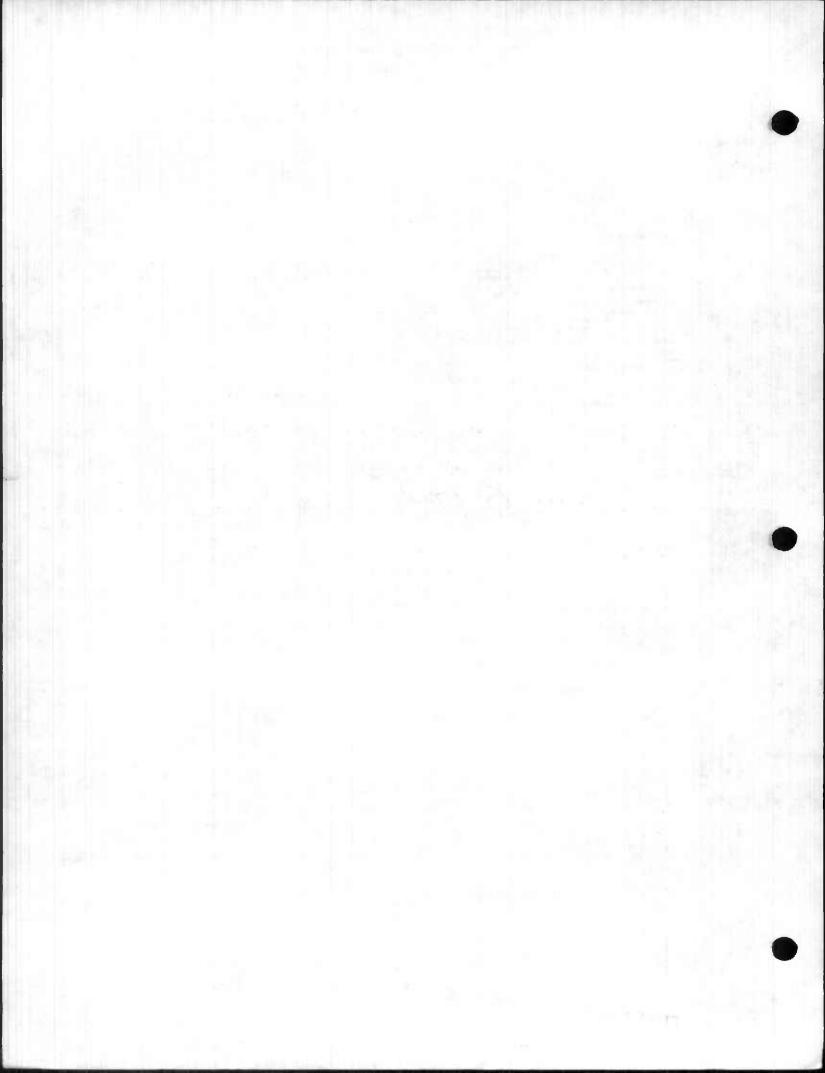
State of Maryland /

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| Department of Health and Mental Hygiene | U | C | U | U |
| Cartificate of Dogth | | | | |

| RD | IVANT | | | | idi yidi | Cen | tifica | te of | Death | ······································ | Reg. No. | | |
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| | Physici Medi/ | | Burnest | | | | Stu | rdiv | ant | Month FEBRUA | ARY 13. | 2000 | 16:29 PM |
| | Examir | | 4a Facility Nama (If not institution, | iva street and number | r) | | | | 4b. City, Town, or | | 1 | ty of Death | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
| 1 | | | 2443 EAST BIDD | LE STREET | | | | | BALTIMO | RE | | | |
| _ | Funeral | | 5. Social Security Number 8 | | ge (In yrs. | last birthday) | | or 1 Year Days | If Under 24 Hrs. Hours Min. | 8. Data of Bi (Month, D. | rth | 9. Birthp | placa (Stata or Foreign |
| п | Director | | 242-26-0198 | IXIM 2□ F | 78 | Yrs. | MONTHS | Days | TIOUIS INIII. | | 23 23 | | C. |
| | 2 . | ' | Usual Residence of Decedant | | 140.00 | - | - 41 | | | | .0 20 | | |
| | d d | - | 10a. Stata 10b. County | | 10c. Cr | ty, Town or Loc | | | | | | 1, | 10d. toside City Limits |
| | ath with the Marylan 23a or 28a-f ahow wat be notified at | Director | MD NA | | | Balt | imo | re | | | | | XXYas 2□ No |
| | \$ 9 P | 吉 | 10e. Street and Number | | | | 10f. Z | ip Code | | | 10g. Citizen of | What Cour | ntry? |
| | 123 m | la l | 2443 East Bio | ddle Stre | et | | | | 213 | | | S.A. | |
| | Rems Dec. m | Funeral | 11. Marital Status | 12. Was Deceden Armed Forces | ? | ,S. 13. W | Yes, sp | edent of F ecify Cub | lispanic Origin? (S an, Mexican, Puert | pecify Yes or No o Rican, atc.) | | ce - Amaric eck, White, | |
| 20 | 0 | by F | 1 Never Married 2 Married 3 XWidowed 4 Divorced | If Yas, Giva |] No | 1 | ☐ Yas | 2 No | Specify: | | Spec | ity: | |
| 21215-0020 | n 72 hours after death with the Maryland "natural", or flems 23a or 28a-f ahow dost. Exercites must be notified at | | | Yaar or Datas | | 16a Dagada | notto Lieu | ual Occur | etion | | 16b. Kind of | Bla | |
| 15 | n 72 | Completed | 15. Decedent's (Specify only highest (| grade completed) | | 16a. Decede (Give k | ind of w | ork done | during most of word) | king | 100. King of | Dusinassin | dustry |
| 72 | within ene. | E | Elementary/Secondary (0-12) | College (1-4or | 5+) | | | | -, | | Baker | 611 | |
| | Hed Hygin | Ö | 12th grade 17. Father's Nama (First, Middla, La | na st) | | D. | ake: | _ | 18. Mothar's Nan | na (First, Middle | | | 1 |
| lan | 025 | To Be | Wilhum Chumdin | | | | | | 3222 | Mar De | 1-1 | | |
| Maryland | and Men a marke aumatic | | Wilbur Sturdiv 19a. Informant's Neme/Reletionship | | | 19b. Mailing | Addras | s (Street | Addie | | | | Code) |
| | 444 | | | | ~ | | | | | | 0367 3376 | | |
| re, | ges 1 and it of Health if Ham 27 or other tr | | Burnest Sturd: 20a. Method of Disposition | ivant Jr. | 20b. | Place of Dispos | ition (Na | on A | ve, Bro | Date | New Yo 20c. Location | City or To | 1-205 own, Stata |
| no | Pages 1 an ment of Haai ant: If Itam 2 uny or other | | 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other, (Spec | | В | cemetary, cremi | | | | 1402-00-0 | | | |
| Baitimore, | permit. Par Department Important: any injury ance. | | 21. Signature of Funeral Service Lic | | Mo | Natio | ona. | 1 Ce | me . 2 | -19-00 | Laur | el, N | id |
| Ba | pemit. Departiments any injury | | | / | 16 | M: | arci | h F | H Wast | | | | |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | u n | JU. | rest 1 | 300 | Wab | ash Ave | , Balt | imore | Md 2 | 21215 Approximata |
| | | | shock, or heart Milure. List on | ly one cause on each | de de de | III. DO NOT enter | r trie mo | de oi dyii | ig, such as cardiac | or respiratory a | irrest, | | Intarval Batween Onset and Death |
| | Physician /Medical | | Immediate Cause (Finel | 11 | + | - | Λ | 1 | / | 1 | | | |
| | Examiner | | disease or condition rasulting in deeth) | · Type | re | -51/2 | 100 | | sidea | VS | | | |
| | | - | | W C | 0 - | or as a consequ | | | 0 . : | | | | |
| | De Tec | Examiner | | | (1 | o Van C | | - | 1117509 | 2 | | | |
| | al-tra | EXB | Sequentially list conditions, if any, leading to immediate | | Due to (c | or es a consequ | ience of |): | | | | 1 | |
| 68760, | ficate be executed g physician and as the buriel-transit | 180 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | ¢ | Dura to to | | | | | | | 1 | |
| 89 | ficett Phy s th | edical | resulting in death) Last | | Due to (o | r as a consequ | ance or) |): | | | | | |
| Вох | centi | \$ | | d | | | | | | | | | |
| Ď | death ce attendir od for usa | Physician/M | Part II Other electricant conditions | annially vision to doubt | h | udina la Maria | 4-4-1 | | un in Do Al | 201-014 | 4-h | and thus a | - the |
| 0 | the c | Jys. | Part II. Other significant conditions | contributing to death | out not res | uiting in tha uni | danying | causa gn | 79n in Part I. | | | | o the cause of death? |
| Δ. | thet deta | | Mostate Co | meer | | | | | | | Yes 2 No | 3 Pro | bably Unknown |
| Records, | v requires that the death certific been signed by the attending p should be detached for use as | Completed by | | | | | | | | 24a. Was | an autopsy | 24b. W | ara autopsy findings |
| CO | shot s | ete | | | | | | | | peri | ormed? | CO | railable prior to emplation of causa deeth? |
| Re | The law ate has b page 2 s | Ē | | | | | | | | 40 | W. Ash | | |
| | ician: Thi | ŏ | 25. Was case referred to medicat | | | · <u>-</u> | | | 00.01 | | Yas 210 No | 11 | ☐ Yes 2☐ No |
| 5 | carti | o Be | examiner? | Hospital: | | EDIO 4 | •□ • | Oth | 26. Place of Dea | | | | 4.3 |
| Division of Vital | Attanding Physician: ir death. sctor: After this cartific by the funaral director. | . To | 27. Manner of Death | 1 ☐ tnpat | | ER/Outpatient 28b. Time of | | UA | 4 LI Nursing H | loma 5 K Res 28d. Describe | how injury occ | | <i>y</i>) |
| on | After fun | 함 | Natural 5 Pending invastigat | 28a. Dete of Inj (Month, D | ay Year) | Injury | м | 28c. Injur Wor | rk? Yas 2 □ No | | ,,,, | | |
| S | al or Attanding P after death. I Director: After i d in by the funan | Certification: | 3 ☐ Suicide 6 ☐ Could not | be one Disco of Ir | niury - At h | oma farm stre | | | | 28f. Location | Street and Num | nber or Run | al Routa Number, |
| $\frac{5}{6}$ | Dir. | T | 4 Homicide detarmine | building, e | ic. (Specif | (y) | 01, 10010 | 19, 0 | | | wn, State) | | |
| | potta soral filler | 2 | 29a. Certifier 1□ Certifying I | Physician: To the best | of my kno | wiedos death | OCCUMEN | d at the tir | me, data and place | and due to the | causals) and r | nannar es e | stated. |
| | To the Hospital or Attending Physician: Tha Is within 24 hours after death. To the Fureral Director: After this cartificate ha completely filled in by the funeral director, page | edical | | aminer: On the basis of and mannar s | of examine | ition and/or inve | estigetio | n, in my o | ppinion, deeth occu | rred at the time, | date end place | , and due to | o tha cause(s) |
| | of the of | \$ | 29b, Signature and title of certifier | ^ | | | 29 | 9c. Licens | se number | | 29d. Date sign | ned (Month, | Day, Year) |
| | - s - ö | | 1 . /10- | Pann | | | | OQ! | TE . | | FEBRUA | RY 14 | , 2000 |
| | 141 | 1 | 20 Namo and address of | ne rout | don't fire | - 02-1 /T T | laine? | | | | | | |
| | 1 | | 30. Name and address of person wh | K (= AAA | ueath (Iten | | | Ct-v | ot Dalt | imom 1 | Marerl an | d 212 | 01 |
| | Sta | 10 | 31. Data filed (Month, Day, Year) | 32. Regist | rar's Sona | | Ma / | JULE | et, Balt | more, | HOT A TOLI | U 212 | J.L |
| | Sta Registr | | 1 0 2000 | Beneva | 15 | popor | and and | | | | | | |

DHMH 16 Rev 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 14 7 Year 2000 THOMPSON Day 6.30AK DANIEL February 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Harborside Health Care Center Baltimore 8. Date of Birth (Month, Day, Year) 07-04-11 5. Social Security Number 578-36-7831 If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **1** M 2□ F Months Days Hours 88 Yrs. NC Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 1830 East 28th Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣ Z No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 KWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Co 5th Grade Laborer 18. Mother's Name (First, Middle, Melden Sumeme) 17. Father's Neme (First, Middle, Last) Unknown Unknown 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 401 K. Street N.W. Apt. #115 Washington, D.C Thompson James 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from Slate 02-19-2000 Randallstown, MD Kings Mem. Pk. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Maryland 21202 March FH 1101 E. North Avenue WM.C. WM.C. MAYON FR IIOI E. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, left only one cause on each ine. 23a. Part 1. Enter the disease, or or shock, or heart failure. List or Approximate Interval Between Onset and Death 9 mfarelion Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work?

1 Yes 2 No

30661

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(a) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year) February 17 (4 2000

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "naturel", or items 23e or 28e-f ahow treumatic event, the Maxical Examinar must be notified at

2 should be filed within 72 hours after death is and Mental Hygiene.
Is marked other than "natural", or flame 224

permit. Peges 1 and 2 st Department of Health and important: If item 27 is n

injury or

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altimore, Maryland 21215-0020

the Maryland

Examiner Physician/Medical

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Completed

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Certification:

edical

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

the death certificate be executed Box 68760, Division of Vital Records, P.O. Hospital or Attending Physician: funeral 24 hours after death. Funerel Director: Af

> State Registrar

FEB 1 8 2000

29b. Signature and title of certifler

5 Pending

Investigation 6 Could not be determined

32. Registrar's Sigpeture

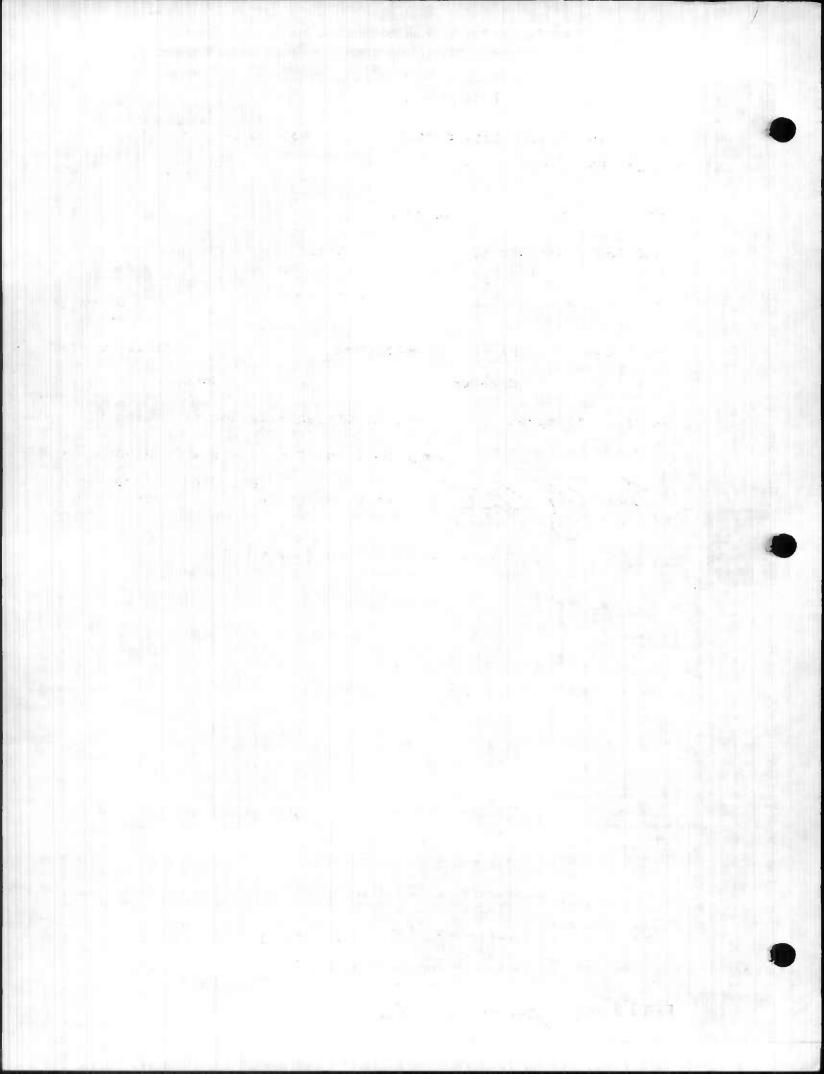
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Streesh TRIPURANEN)
H700 Harford Rol, Ballinere, Itd - 21714

oaks

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

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To the I



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name /First Middle Last 2. Date of Death 3. Time of Death **Physician** FURWAY 15

At City, Town, or Location of Deeth 4c. pm , 2000 Frank Tillman /Medical 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner taltimore City NA Greneral 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country)
 S C 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours Min MAN 2□F Yrs. 67 Director 242-44-5153 07-18-32 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□ Yes 2□ No MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 447 East 22nd. Street 21218 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: XIX Never Merried 2 Merried Specify: Black 1 ☐ Yes 2 No Specify: ğ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Water Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Laborer 10th Grade 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) 88 Henry tillman Della McManus 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr.+Mrs. Edwin Farley 2853 W. Mulberry Street Baltimore, MD 21223 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal I 4 Donation 5 Other (Specify) Voshell Mem. Gardens 02-21-2000 Dundalk, MD Signality Funerel Service Licent 22. Name end Address of Fecility Baltimore, Maryland 21202 Print Enter the disease, or complication shock, or heart feilure. List only one ca WM.C.March FH 1101 E. North Avenue In the indeed the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and the line. Approximate Interval Between Onset and Death **Physiclan** Accident /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably 4 ₺ Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to 24a. Was en autopsy Completed completion of cause of death? 1□ Yes 212 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Sulcide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homloide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29b. Signature and title of certifier

State Registrar 30. Name and address-et p

31. Date filed (Manth, Day, Year) FEB 1 8 2000

Bhatz

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jak flanc

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DHMH 16 Rev 6/95

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ed other than "natural", or items 23s or event, the Medical Examiner must be

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72 hours after

should be filed within

Pages 1 and 2 Item 27

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Baltimore,

Hygiene.

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After or Attending

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24 hours after deetle Funeral Director:

To the F within 2 To the F

funeral

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The law requires that the death certificate be executed

Box 68760.

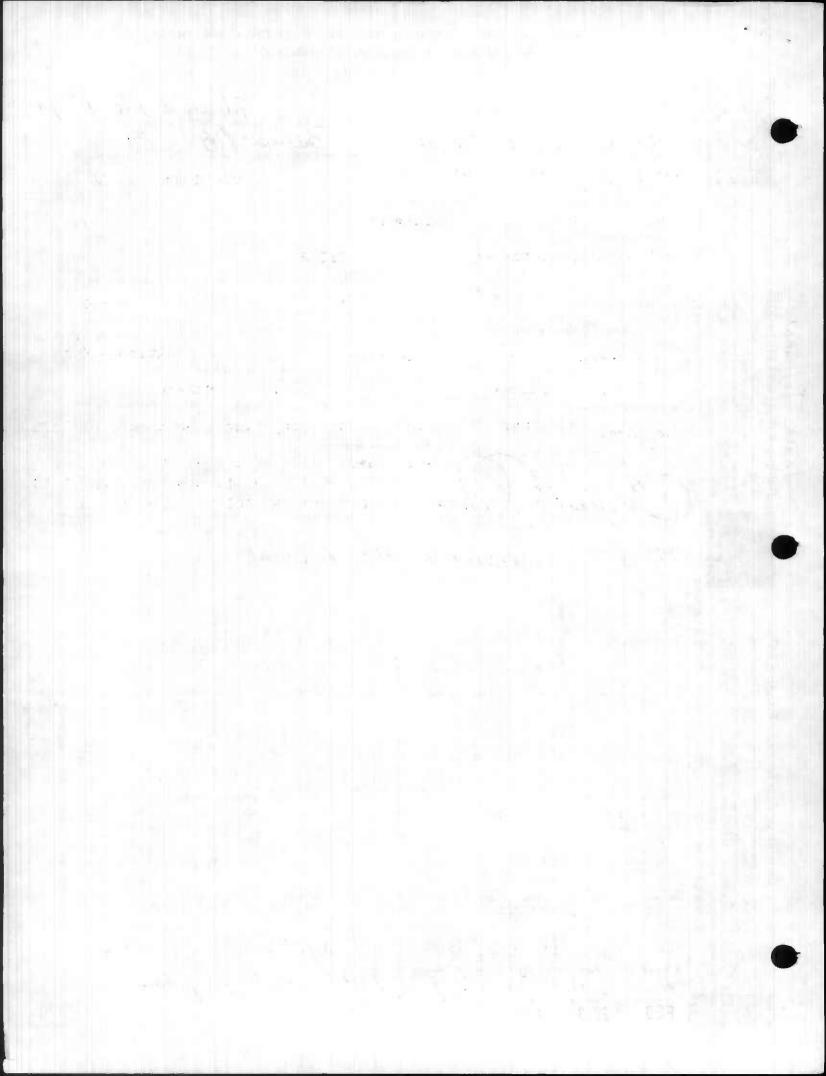
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Division of Vital Records,

29c. License number

29d. Dete signed (Month, Dey, Year)

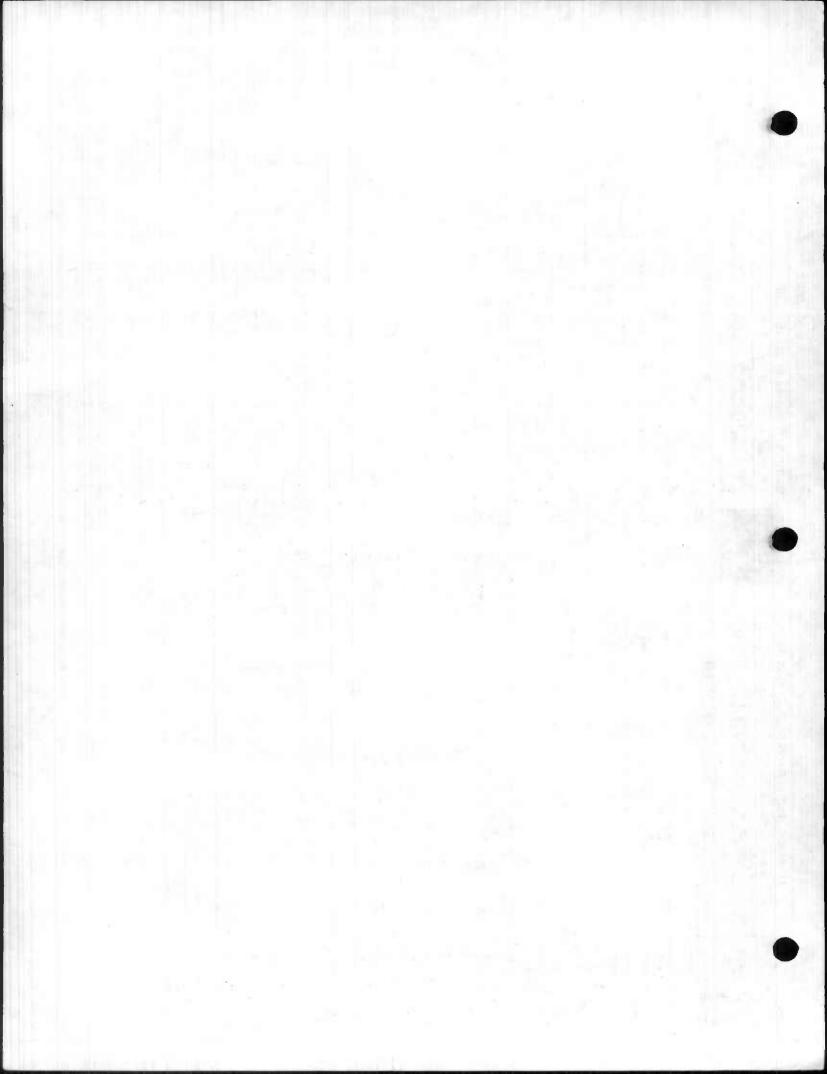


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 15, a 9:36 am **Physician** Dorothea Agnes Taylor 15,200 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen unde 7. Age (In yrs. last birthday) Burnie Arunde If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 200 Hours 170-42-9825 56 Director Nov. 16, Germany **Usual Residence of Decedent** the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Gambrills Anne Arundel 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 21054 1110 Flowering Tree Court USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 21215-0820 White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government . Pages 1 and 2 should be flied w timent of Health and Mental Hygies tant: If hem 27 is marked other to jury or other traumetic event, to Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Emil Kugel Elisabeth Hummel 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Ray Taylor (Husband) 1110 Flowering Tree Court, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 02/17/ 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stata Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2000 Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signatura of Euperal Service Licensee ala an 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feitime. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Causa (Finat disease or condition rasulting in death) Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last physician the burial Box 68760, Physician/Medical Due to (or as a consequence of) 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown signed t Division of Vitai Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has page 2 1 Yes 2 No 1 Yes 2 10 No or Attending Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2FI No 1 2 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 5 Pending investigation 1 Neturat 24 hours after death.

Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a, Certifie completely (Check only one) within 2 5 29b. Signatury and title of certifie 29d. Date signed (Monthy Day, Year) 29c. License number ann adducts of person who completed cause of death (Item 28a) (Type, Print) MD 300 Hospital Drive, Glen Burnie, MD 21061 Jorge Ramirez, 31. Date filed (Month, D Year) Day 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

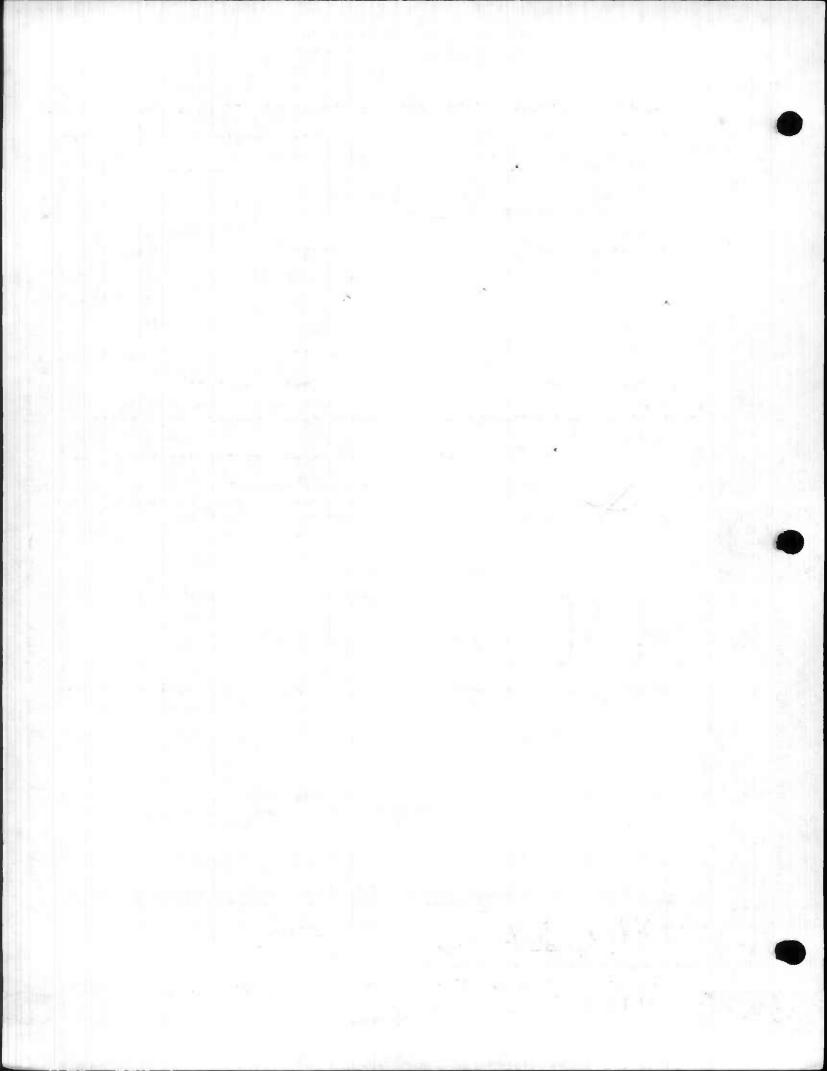


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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| п | Physic | ian | 1. Decedent's Name (First, Middle, L | | | | | | 2. Date of De Month | eth Dev | Yeer | 3. Time of Death |
| | /Medi | | Elizabeth M. Tho | omassy (a | ka Bet | tty M. | Th | omassy) | 02 | 11 20 | | 12:20am |
| 1 | Exami | ner | 4e. Fecility Neme (If not institution, g Millenium Hea | | .b | | | 4b. City, Town, or Glen E | | , | | undel |
| | Funeral Director | Г | 5. Sociel Security Number 6. 176 - 36 - 6930 | The same of the sa | In yrs. last birth | nday) If Und Month | er 1 Year Deys | Hours Min | . (Month, Di | rth ay, Year) 1914 | 9. Birthpli Count | ece (State or Foreign ry) A |
| | pu . | | Usual Residence of Decedent 10e. State 10b. County | | 0c. City, Town | and agetism | | | | | | |
| | e Maryla ta-f shor | Director | Md Anne A | | Arno. | | | | | | 10 | od. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | or 28 | Dire | 10e. Street and Number | | | 10f. 2 | ip Code | | | 10g. Citizen of | What Count | ry? |
| | 23a | Ta | 548 Norton La | ne | | | | 1012 | | | SA | |
| 020 | i within 72 hours efter death with the Maryland ilene. Than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at | by Funeral | 11. Maritel Stetus 1 Never Married 2 Married 3 KWidowed 4 Divorced | 12. Wes Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | er in U,S. | | | lispanic Orlgin? (: en, Mexican, Pue Specify: | Specify Yes or No rto Rican, etc.) | Specify | ck, White, e | itc. |
| 21215-0020 | na' | Compieted by | 15. Decedent's I (Specify only highest g | rade completed) | 16e. [| Decedent's Us 'Give kind of w life. DO NOT | ual Occup rork dona usa ratire | pation during most of wo d) | orking | 16b. Kind of B | usiness/Ind | ustry |
| 213 | | EO | Elemantary/Secondary (0-12) | Collega (1-4or 5+) | | Tead | her | Aide | | Edi | ıcati | on |
| nd | 0 = 0 \$ | Be | 17. Father's Name (First, Middle, Las | | | | | | ma (First, Middle | | 10) | |
| Ya | | ဥ | Jay Kerr McCa | | | | | | Campbe | | | |
| Maryland | and and s m | | 19a. Informent's Name/Relationship | | | | | and Number or R | | | | |
| | leal m 2 her | | Katherine Harm 20a. Method of Disposition | | | | | Lane, | Deta | , Ma. | 210] | |
| Baltimore, | permit. Pages I Department of F Important: If ite any injury or of once. | | 1 Burlal 2 Cremation 3 4 Donation 5 Othar (Spec | A THEIROVER HOLLI STATE | 20b. Placa of I cemetery Tri-Si | | | atory | | | | |
| Ball | Depart Import any in | | 21. Signature of Funural Service Lion | 90899 | | Sterl | ling | | | | | Home, Inc |
| | | | 23a. Pert1. Enter the disease, or con shock, or neert failute. List onl | mplications that caused the yone cause on each line. | e death. Do no | t enter the mo | ed m o | ndson A | venue, ac or respiratory e | Balto errest, | , Md | 21228 Approximate Interval Between Onset and Death |
| 2 | Physician /Medical Examiner | | Immediete Cause (Final disease or condition | Asp | iratio | n Pne | umor | nia | | | | 8 days |
| п | - Addition | <u>.</u> | resulting In deeth) | Du | e to (or as a co | onsequance of | ·): | | | | İ | |
| | and transit | Examiner | Sequentially list conditions, | b. Cere | ebrova e to (or as a co | scula onsequenca of | r Ac | cident | | | | 8 days |
| 68760, | tificate be executed to physician and as the bunal-transit | | Sequentielly list conditions, if any, laading to Immediata causa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest | | onary e to (or as e co | | | sease | | | | 7 years |
| Box 6 | 2 0 6 | Physician/Medical | | d. Esse | ential | Нуре | rter | sion | | | 1 | 2 years |
| | the death ceily the ettendir | sicla | Pert II. Other significent conditions | contributing to death but n | not resulting in t | the underlylna | cause giv | en in Part I. | 23b. Did | tobacco use co | ntribute to | the cause of death? |
| P.0 | that the de ned by the e deteched | | | | | | | | | Yee 2⊠ No | | ably 4 Unknown |
| Records, | e law requires that hes been signed b ge 2 should be dete | Completed by | | | | | | | | en eutopsy ormed? | ave | re autopsy findings ileble prior to apletion of cause eath? |
| ď | The law ate hes b page 2 s | mo(| | | | | | | 10 | Yes 2 XNo | 1 🗆 | Yes 2□ No |
| Vital | iclan: The certificate rector, pag | Be (| 25. Was casa raferred to medical axaminer? | | | | | | ath (Check only | one) | | |
| حتياه | Q 50 | lon: To | 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒Natural 5 ☐ Pending | Hospitel: 1 Inpatient 28a. Deta of Injury (Month, Day Ye | 2 ER/Outp | ne of ury | 28c. Injui Wor | y at k? | Home 5 Res | denca 6 Oth | |) |
| Division | To the Hospital or Attending Ph within 24 hours afferd death. To the Funeral Director: Affer th completely filled in by the funeral | Certification: | 2 Accident investigation 3 Sulcide 6 Could not datermined | De Diana et latura | - At home, fam Specify) | M n, street, facto | | Yas 2□No | 28f. Location (City or To | Street and Numb wn, State) | er or Rural | Route Number, |
| Ī | Hospita 24 hours Funeral stely filled | edical C | 29a. Certifiar 1 Certifying P (Check only one) 2 Medical Exa | hyalcian: To the best of miner: On the basis of ex and menner stated | amination and/ | death occurre or Invastigatio | d et the tir | ne, date and place pinion, death occ | e, end due to the urred et tha tima, | ceusa(s) and ma date and placa, | anner as ste and due to | ited. the cause(s) |
| | ompk | Me | 29b. Signature and little of centifier | A A | | 2 | 9c. Licens | D14160 | | 29d. Date signe | d (Month, E | Day, Year) |
| | F > F 0 | | 1 Starp | duft 1 | iD. | | | 14160 | - | | 1/20 | |
| | 2 | | 30. Name end addrass of person who | | | | | | | | | |
| | | • | Harjit Sing | h, M.D. 54 | 110-A Signeture | Ritch | ie H | ighway | Baltim | ore, M | d. 2 | 1225 |
| | Sta Registr | ie ar | 31. Date Hee (Moath, Bay, Year) | Senera | 4 | 100 | | | | | | |

Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend item 5, 18 per fh G780 2/25/00 ystate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vrzalik Henry Joseph February 15, 2000 5:45 PM /Medical 4a Facility Neme (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Center Baltimore Baltimore 5. Social Security Number 75 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1**∑** M 2□ F 73 Yes 215-22-9478 New York Director Aug. 10,1926 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Director Maruland Baltimore. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8919 Mavis Avenue 21236 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🛛 No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) Photographic Company Installer-Serviceman other 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if item 27 is marked other any injury or other traumatic event obcs. 17. Father's Name (First, Middle, Last) 8 Vidalk Anna Vidlak Vrzalik Leo A. 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Libbie Vrzalik (wife) 8919 Mavis Avenue, Baltimore, MD 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 □ Cremation 3 □ Removel from State Gardens of Faith Cem. 2/18/00 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, Maris

Physician /Medical Examiner

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signed by the

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To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral

by

Completed

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Certification:

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Box 68760.

Records, P.O.

Division of Vital

disease or condition resulting in death) Examiner physician s s the burial Physiclan/Medicai

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Finel

End Stark

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart tailure. List only one cause on each line.

Due to (or as a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did lobacco usa contributa to the cause of death? 1 ☐ Yaa 2 No 3 Probably 4 Unknown

21236

Approximeta Interval Between Onset and Deeth

24a. Wes an autopsy performed?

24b. Wera autopsy findings available prior to completion of cause of death?

1□ Yes 2 No

1 Yes 20 No

25. Was case referred to medical axaminer? 1 Yes PRINO

Hospital: 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 | Inpetient 2 | ER/Outpetient 3 | DOA

Other: 4 Strursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Menner of Death

2 Accident

3 ☐ Suicide

4 Homicide

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

6 ☐ Could not be

29c. License number 306 29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapathi 821 Euraw St # 308 Baito. Md. 21201 ramesh N. 31. Date tiled (Month, Day, Year)

State Registrar

FEB 1 8 2000

32. Registrar's Signature

Darks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** C. Edward Victor 2000 12:45 AM 16 February /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner edale enter anklin /uare tospital 1 more If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs last birthday) **Funeral** Days Months 1 Ø M 2 □ F 76 186-14-6450 31, 1923 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural; or Items 23a or 28ad show any injury or other traumatic event, the Medical Francisco must be notified as any injury or other traumatic event, the Medical Francisco must be notified as any injury or other traumatic event, the Medical Francisco. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20 Juliet Lane. Unit #103 21236 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried White 1 Yes 2 No Specify: Specify. ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Technician Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Victor Louise Katra John 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Juliet Lane, Unit#103, Baltimore, MD Mrs. Josephine Victor (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) Green Mount Crematory 12/19/00 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signeture of Funeral Service Licenses Marke 9705 Belair Rd., Baltimore, MD 21236 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth 23a. Part1. Enter the disease, or conshock, or heart feilure. List on **Physician** /Medical Immediate Cause (Finel lelanoma ears disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Due to (or es a consequence of): Box (P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yaa 2X No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 1 Yes 200No 1 ☐ Yes 2 ☐ No of Vitai Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Division or Attending 1 Natural 5 Pending investigation in birector: Affi 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Funeral edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as atated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely t (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signeture and title of certifier 1.0. Uhlman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ackerman 9000 Franklin

Registrar

State

31. Date filed (Month, Day, Year)

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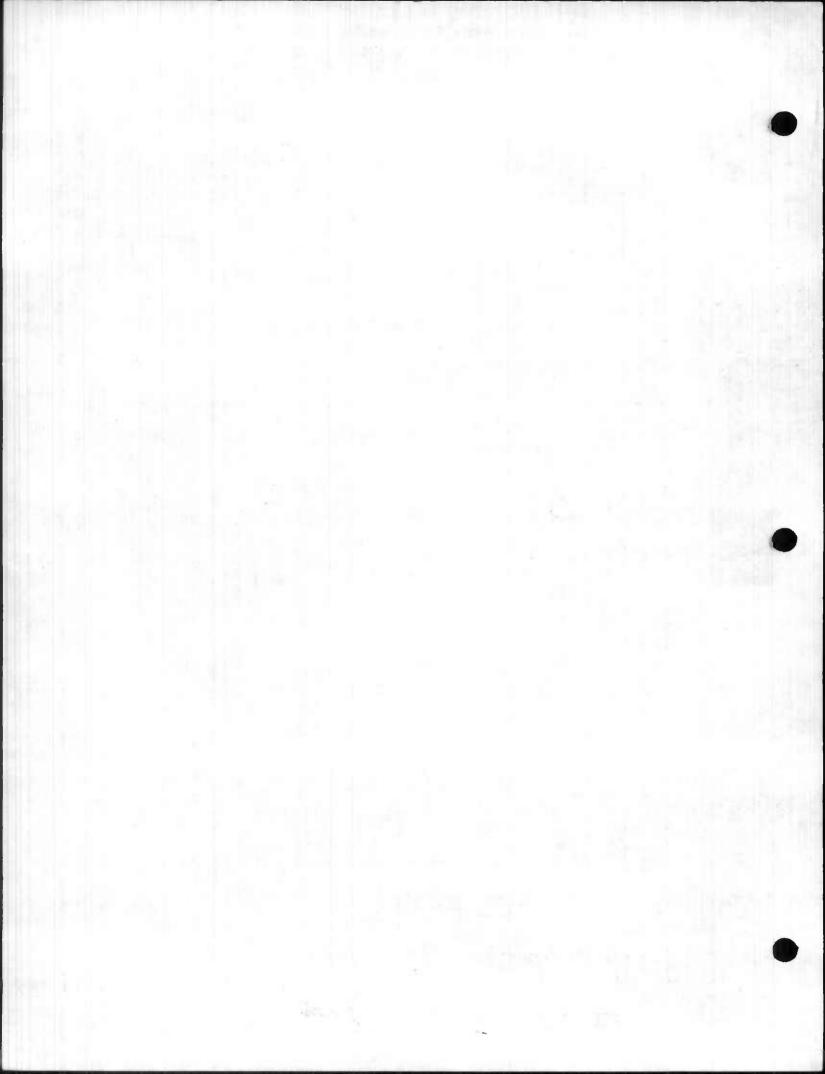
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32. Registrar's Signature

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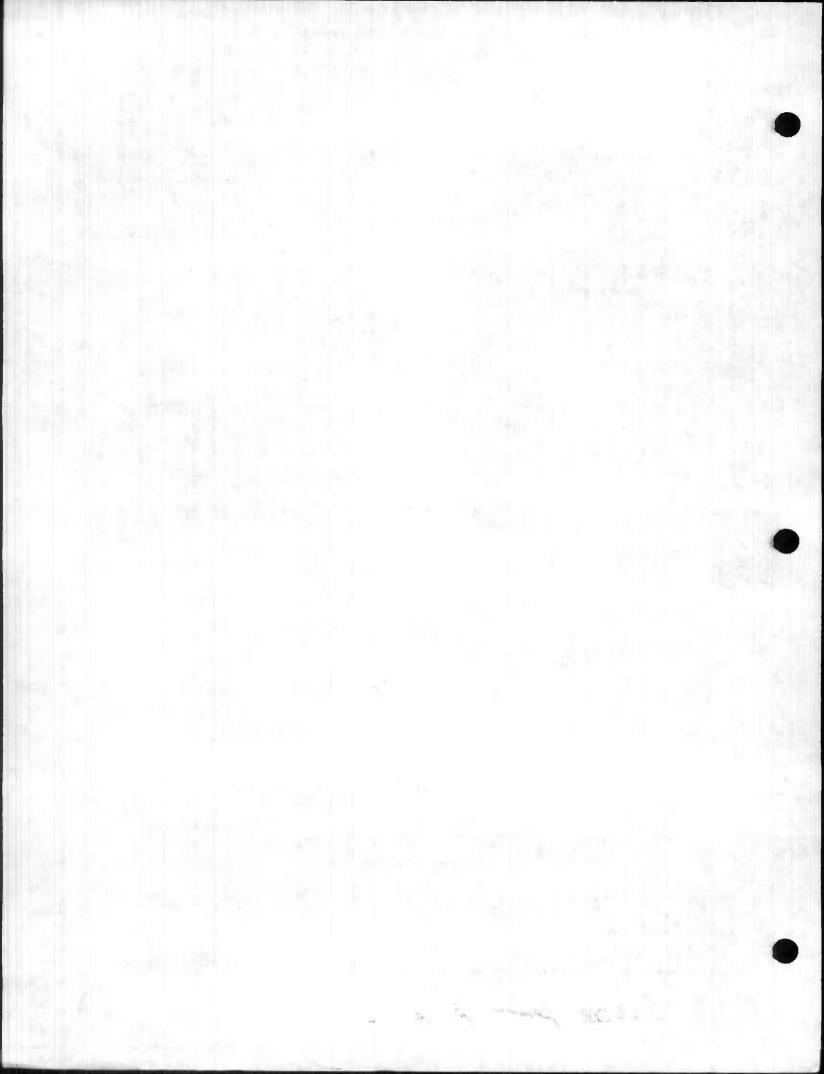
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State of Maryland / Department of Health and Mental Hygiene 11 15 17

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| | 1. Decedent's Nar | me (First, Middle, La | st) | | | | | | Data of Death Month | Day Y | 'ear | 3. Time of Death |
| Physician /Medical | Gerald | line P. Wo | mack | | | | | | ebruary | 16 2 | | Ipm |
| Examiner | 4a Facility Nama | (If not institution, giv | a street and number) | | | | 4b. City, Tov | wn, or Locati | ion of Death | 4c. County of | | |
| | Sina | i Hosp | ital of | - Berl | tim | one | 150 | altin | none | | N/A | |
| Funeral | 5. Social Security | Number 6. S | Sex xX 7. Ag | e (In yrs. last | birthday) | If Under 1 Yes | | Min. 8. | Date of Birth (Month, Dey, Ye | | | e (Stata or Fora |
| Director | 220-36- Usual Residence | -5559 | I□M ŽŪF | 60 | Yrs. | Months Day | s Hours | MIF1. | 11-14- | | V | |
| B 10 | 10a. State | 10b. County | | 10c. City, T | own or Loc | cation | | | | | 10d | . Inside City Limi |
| with the Maryar a or 28s-f show be notified at Director | MD | N/A | | Ba1 | timor | e | | | | | | XX Yes 2□N |
| or 25s-f s be notified Director | 10e. Street and Nu | umber | | | | 10f. Zip Code | | | 10g | Citizen of Wh | at Country | ? |
| 23a or unt be | | se Crest | Ave. | | | 2121 | | | | USA | | |
| r flame 23 siner must Funeral | 11. Maritel Status | | 12. Wes Decedent Armed Forces? | Ever in U,S. | 13. V | Vas Decedent of Yes, specify Cu | Hispanic Original Hispanic Origin Hispanic Origina Hispanic Origina Hispanic Origina | in? (Specify Puerto Rice | y Yes or No- an, etc.) | 14. Rece - Black, | American White, etc | |
| b, 6 | | rried 2 Married | 1 ☐ Yes XXI If Yes, Give Yeer or Dates: | | | □Yes 2∏N | | | | Specify B | | |
| ygiene. ygiene. t, the Medical Exami Completed by F | (Spe | 15. Decedent's Ed | ducation ada completed) | 1 | (Giva I | ent's Usuai Occ kind of work dor | a during most | of working | 160 | . Kind of Busi | ness/Indus | stry |
| and de | Elementary/Sec | ondery (0-12) | College (1-4or | 5+) | | OO NOT usa reti | red) | | | | | |
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| and m m | | Neme/Reletionship (| | | | | | | outa Number, C | | | ode) |
| 27 m | EVELYN | HAINESWOF | RTH/MOTHER | | | | CREST | AVE. I | BALTO., | | | |
| ant of Hu th if flam y or oth | | • | Removal from State | 20b. Place cemi BARN | a of Dispos atany, cram ES FA | sition (Name of natory or other p MILY CE | laca) METERY | 2/2 | 25/2000 | BRUNSW | | |
| HEE. | | Funeral Service Licer | | | 22 | . Name and Add | ress of Fecility | v | | | | |
| 0 1 1 0 | () a | 2000 | Sulat | Ta. | J | AMES A. | MORTO! | N & SC | ONS F.H. | | 7 | |
| | 23a Panty Enter | the disease or corr | piications that cause one cause on each li | the death | Do not ente | /UI LAU | KENS S | Cardiac or re | LTO., ME | . 2121 | | pproximete |
| nding physician and use as the burial-transit | | | | | | | | | | | | |
| 0 8 | The initial ed events resulting in deeth) Lest Due to (or as a consequence of): | | | | | | | | | | | |
| 2 2 2 | | | d | | | | | | | | | |
| - P - P | Part II Other elan | iticant conditions o | | ut not resultin | on in the un | adertuing cause | niven in Part I | | 23h Did toha | cco use confi | ribute to ti | he cause of de |
| by the atternached for thysicial | Pert II. Other sign | ificant conditions of | contributing to death b | ut not resultir | ng in the un | nderlying cause | given in Part I. | | | | ribute to ti | , |
| igned by the atter be detached for a by Physicial | Pert II. Other sign | ificant conditions of | | ut not resultir | ng in the un | nderlying cause | given in Part I. | | | 2□No 3 | Probe | a autopsy findin abla prior to oletion of cause |
| has been signed by the atterned for the street of the stre | Pert II. Other sign | ificant conditions of | | ut not resultir | ng in the un | nderlying cause | given in Part I. | | 1 Yes | 2□No 3 | 24b. Were avail compof de | a autopsy findin abla prior to oletion of cause |
| are has been signed by the atterpage 2 should be detached for Completed by Physicial | 25. Was case refe | | | ut not resultir | ng in the un | nderlying cause | | | 1 Yes 24a. Was an a performe | 2□ No 3 | 24b. Were avail compof de | autopsy findin abla prior to oletion of cause eth? |
| artificate has been signed by the atter- octor, page 2 should be detached for Be Completed by Physicial | | arred to medical | contributing to death b | | ng in the un | | 28. Place | of Death (C | 1 Yes | 2□ No 3 | 24b. Were avails compof de | autopsy findin abla prior to oletion of cause eth? |
| his certificate has been signed by the after all director, page 2 should be deteched for To Be Completed by Physicial | 25. Was case refe axaminer? 1 □ Yes 2 € 27. Manner of Des 1 ②Natural | erred to medical ☑No ath 5 ☐ Pending | Hospital: 1 Impati | ent 2□ER | | at 3□ DOA 1 28c. Ir | 28. Place Other: 4 □ Nu | of Death (Carsing Home | 1 Yes 24a. Was an a performe 1 Yes Check only one) | 2□ No 3 utopsy d? 2□No | 24b. Were available comported to the com | autopsy finding bletion of cause eth? |
| wher death. Mector: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for extification: To Be Completed by Physicial | 25. Was case refe examiner? 1 \subsection Yes 2 \overline{2} | arred to medical No ath 5 Pending investigatio 6 Could not b | Hospital: 1 Impati 28a. Date of Inju (Month, De | ent 2⊡ER ıry y Year) 28 | VOutpatien Bb. Time of Injury | at 3 DOA 28c. Ir | 28. Place Other: 4 □ Nu jury at york? □ Yes 2 □ | of Death (Corsing Home 28c | 1 Yes 24a. Was an a performe 1 Yes Check only one) 5 Residence | 2 No 3 utopsy d7 2 No a 6 Other injury occurred and Number | 24b. Were avail compored to de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | bly 4 Onkr a autopsy findin abla prior to oletion of cause eth? |
| wher death. Director: After this certificate has been signed by the after in by the funeral director, page 2 should be detected for set if the funeral director. Be Completed by Physicial | 25. Was case refeaxaminer? 1 Yes 2 2 27. Manner of Dea 1 PNatural 2 Accident 3 Suicide | arred to medical No ath 5 Pending investigatio 6 Could not b determined | Hospital: 1 1 Impati 28a. Date of Injuiding, el | ent 2 ER y Year) 28 jury - At home c. (Specify) of my knowle f examination | VOutpatien b. Time of Injury e, farm, stre | 28c. Ir W 1 eet, factory, office | 28. Place Other: 4 Nu jury at ork? Yes 2 1 | o of Death (Consing Home 28c) No 28f | 1 Yes 24a. Was an a performe 1 Yes Check only one) 5 Residence 1. Describe how Location (Stree City or Town, Stree | 2 No 3 utopsy d? 2 No a 6 Other injury occurred and Number State) | 24b. Were avall comported to the comport | bly 4 Minkn s autopsy finding able prior to oletion of cause eth? Yes 2 No |
| iffer death. Director: After this certificate has been signed by the after in by the funeral director, page 2 should be deteched for set in the funeral director. Entitication: To Be Completed by Physicial | 25. Was case refe examiner? 1 Yes 2 2 27. Manner of Des 1 | arred to medical No ath 5 Pending investigatio 6 Could not be determined | Hospital: 1 Impatis 28a. Date of Injurysician: To the best | ent 2 ER y Year) 28 jury - At home c. (Specify) of my knowle f examination | VOutpatien b. Time of Injury e, farm, stre | 28c. Ir V M 1 eet, factory, office | 28. Place Other: 4 Nu jury at ork? Yes 2 1 | o of Death (Consing Home 28c) No 28f | 1 Yes 24a. Was an a performe 1 Yes Check only one) 5 Residence d. Describe how Location (Street City or Town, Street City or Town, | 2 No 3 24b. Werse avalled composed of the second of | a sutopsy finding abla prior to oletion of cause eth? Yes 2 No Routa Number, |
| To a hours after death. • Funeral Director: After this certificate has been signed by the atterpletely filled in by the funeral director, page 2 should be detected for edical Certification: To Be Completed by Physicial | 25. Was case refe examiner? 1 Yes 2 2 27. Manner of Dea 1 12 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifiar (Check only) | arred to medical No ath 5 Pending investigatio 6 Could not be determined | Hospital: 1 1 Impati 28a. Date of Injuiding, el | ent 2 ER y Year) 28 jury - At home c. (Specify) of my knowle f examination | VOutpatien b. Time of Injury e, farm, stre | 28c. In 28c. In V W 1 1 seet, factory, office occurred at the vestigation, in m | 28. Place Other: 4 Nu jury at lork? Yes 2 lea time, date en y opinion, dea | o of Death (Consising Home 28c No 28f d placa, and th occurred | 24a. Was an a performe 1 Yes Check only one) 5 Residence 1. Describe how Location (Stree City or Town, Street City or Town, Street City and Street City or Town, Street City and Street City or Town, Street City and Stree | 2 No 3 utopsy d? 2 No 0 a 6 Other injury occurred and Number injury occu | 24b. Werse available composed of de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | e autopsy finding abla prior to oletion of cause eth? Yes 2 No Routa Number, led. he cause(s) |
| Mer death. Director: After this certificate has been signed by the after in by the funeral director, page 2 should be deteched for in by the funeral director, page 2 should be deteched for a stratification: To Be Completed by Physicial | 25. Was case refe examiner? 1 Yes 2 2 27. Manner of Des 1 | arred to medical No ath 5 Pending investigatio 6 Could not be determined | Hospital: 1 1 Impati 28a. Date of Injuiding, el | ent 2 ER y Year) 28 jury - At home c. (Specify) of my knowle f examination | VOutpatien b. Time of Injury e, farm, stre | 28c. In 28c. In V W 1 1 seet, factory, office occurred at the vestigation, in m | 28. Place Other: 4 Nu jury at lork? Yes 2 lea time, date en y opinion, dea | o of Death (Consising Home 28c No 28f d placa, and th occurred | 24a. Was an a performe 1 Yes Check only one) 5 Residence 1. Describe how Location (Stree City or Town, Street City or Town, Street City and Street City or Town, Street City and Street City or Town, Street City and Stree | 2 No 3 utopsy d? 2 No 0 a 6 Other injury occurred and Number injury occu | 24b. Werse available composed of de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | a sutopsy finding abla prior to oletion of cause eth? Yes 2 No Routa Number, led he cause(s) |
| wher death. Overcor: After this certificate has been signed by the after in by the funeral director, page 2 should be deteched for such the funeral director. Be Completed by Physicial | 25. Was case reference axaminer? 1 Yes | arred to medical No ath 5 Pending investigatio 6 Could not be determined 1 Certifying Ph 2 Medical Examined | Hospital: 1 Propation of the last of the l | ent 2 ER If Year) 28 y Year) 28 jury - At home (c. (Specify) of my knowle of examination ated. | VOutpatien Db. Time of Injury e, farm, streeding, death and/or inv Ph. Ba) (Type, I | 28c. In 28c. In V W 1 1 seet, factory, office occurred at the vestigation, in m | 28. Place Other: 4 Nu jury at lork? Yes 2 lea time, date en y opinion, dea | o of Death (Consising Home 28c No 28f d placa, and th occurred | 1 Yes 24a. Was an a performe 1 Yes Check only one) 5 Residence d. Describe how Location (Street City or Town, Street the time, date | 2 No 3 utopsy d? 2 No 0 a 6 Other injury occurred and Number injury occu | 24b. Werse available composed of de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | bly 4 Onkr a sutopsy findin abla prior to oletion of cause ath? Yes 2 No Routa Number, ed. he cause(s) |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | \(\) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5-15 My Mary Chaney White 4b. City, Town, or Location of Death HOSPITAL

JEN BURNIE

Month Jay Hunder 1 Year Hunder 24 Hrs. 8. Date of Birth (Month, Day, Jan. 17, 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner COUNTY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 20XF 213-50-2193 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Herne 23s or 28s-f show 1 Yes 200No Director Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12307 Quailwoods Drive 20874 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: White à 3K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be trid Mental James Chaney Agnes Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) partment of Health an Important: If them 27 is n any Injury or other FRES 12307 Quailswood Drive, Germantown, MD 20874 Sally Rigler (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 02/22/ XXBurial 2 ☐ Cremation 3 ☐ Removal from State 2000 Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Preumonia fmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury 68760 Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequence of): Box (23b. Did tobacco use gentribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Dement 9 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has 1 Yes 2 No 1 Yes 2 No Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P Certification: 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation 1 Yes 2 No death. apital or Attenditions after death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely lilled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier

Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year) FEB 18

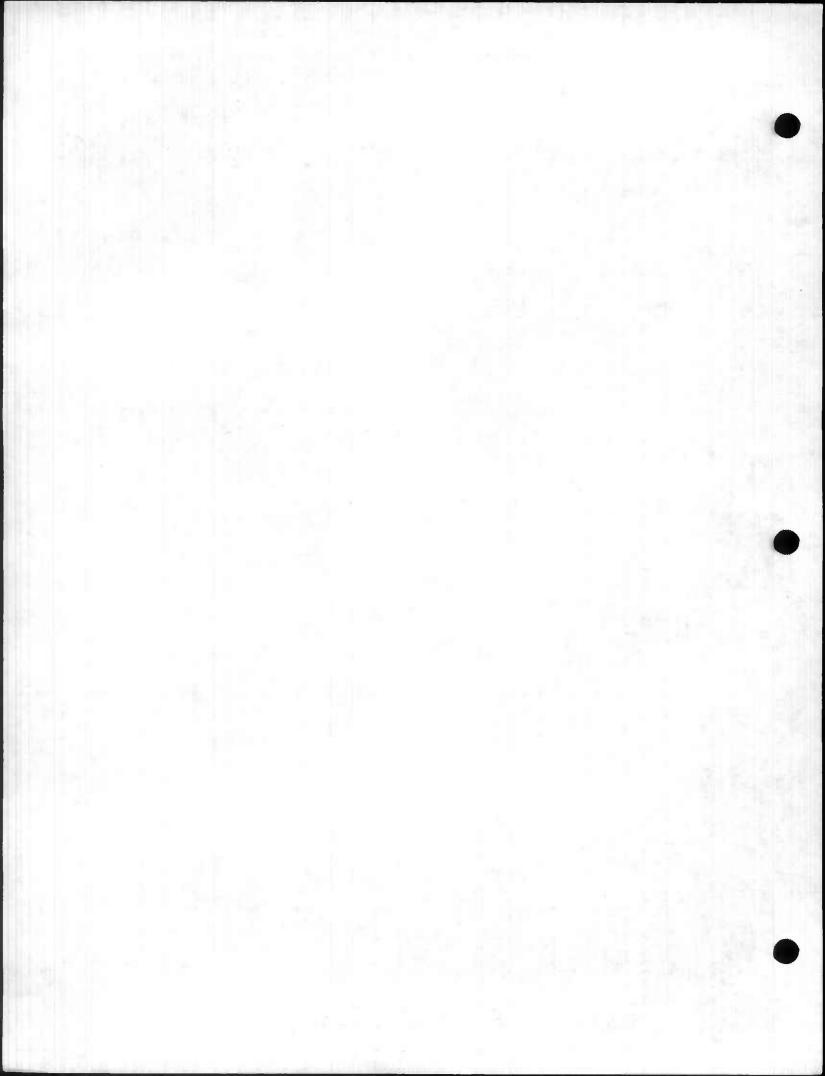
29b. Signature and title of certifler.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 201 Crain Towers

Alen Burnil Md 2/061 Dalvit Sawhnev. MD 32. Registrar's Signature

29c. License number D 1 4 1 3 6

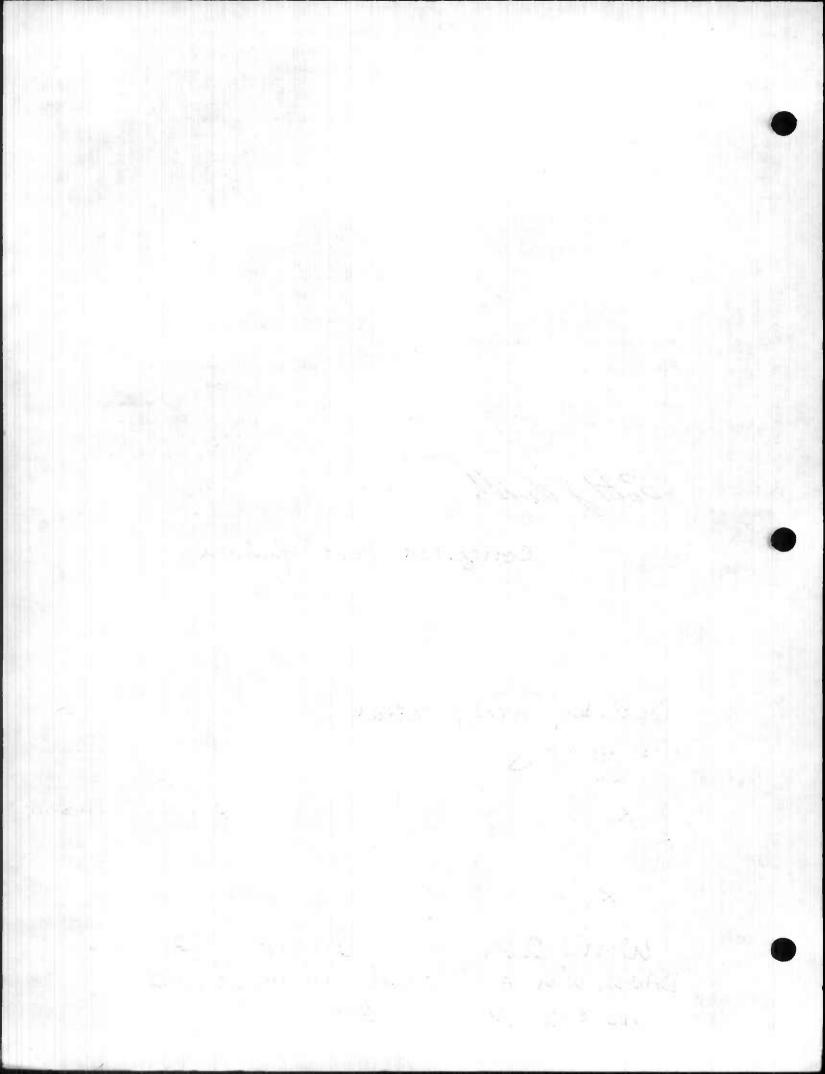
29d, Data signed (Month, Dav. Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | | Olale O | i waiyia | | ertificate | | Death | | Reg. No. |) 0 | 5019 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------|----------------------|-------------------------------------|----------------------------------------------------------------------------|------------------------------------------|------------------------------------------|--------------------|----------------------------|-------------------------------------------|
| | | | 1. Decedent's Name | a (First, Middle, L | ast) | | | | | | 2. Date of De | ath | | 3. Time of Death |
| | Physician /Medical Examiner | _ | Blaine Lo | ouis Wed | dell | | | | | | Februa | ry 16, | Year 2000 | 1:50pm |
| | | | 4a Facility Name (I | f not institution, gi | va street and nun | nber) | | | 7 | lb. City, Town, or I | ocation of Death | 4c. Cour | ty of Death | |
| | | 1) | 450 Poplar Leaf Drive Edgewater Anne Ar | | | | | | | | e Arui | ndel | | |
| | Funeral Director | | 5. Social Security N 480-22-35 | | Sex 1☑ M 2□ F | 7. Age (In yrs. 75 | last birthda Yrs. | y) If Under 1 Months E | Year | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da Nov. 24, | th y, Year) | 9. Birthi Coul I OWa | place (State or Foreign htry) |
| Н | ** | | Usual Residence of | | | | | | - | | NOV. 24, | 1724 | IOWa | |
| | show show stat | | 10a. State | 10b. County | | 10c. Ci | y, Town or | Location | | | | | | IOd. Inside City Limits |
| | diffe | cto | MD | Anne A | rundel | Edg | gewate | er | | | | | | 1 ☐ Yes 2/☐ No |
| | | I Director | 10e. Street and Nur 450 Popla | | Drive | | | 101. Zip Co | ode .03 | 7 | | 10g. Citizen o | f What Cou | ntry? |
| | er desth Items 2 Der mus | Funeral | 11. Marital Status | | 12. Was Dece | dent Ever in U | ,S. 13 | B. Was Deceden | t of H | ispanic Origin? (S In, Mexican, Puert | pecify Yes or No | 14. B | sce - Ameri | |
| 020 | hours after unsif, or its at Examiner | by Fu | 1 ☐ Never Marri 3 ☐ Widowed | ed 21 Married | Armed For 1 [2] Yes If Yes, Giv Year or De | 2 No | | 1 ☐ Yes 2 🖔 | | | o Hican, etc.) | | ack, White, ify: Wh: | |
| 0 | 2 ho | | 10 | 15. Decedent's E | ducation | | 16a. Dec | edent's Usual C | ccup | ation | Asia a | 16b. Kind of | Businass/In | dustry |
| 21 | E | Completed | Elementary/Seco | ify only highest gr ndary (0-12) | College (1 | -4or 5+) | life | DO NOT use | netined | during most of wor f) | King | | | |
| 2 | or the | Con | 12 | | | | Civil Servi | | ic | | | US Go | | ent |
| P. | Antal H Antal H And off Scever | Be | 17. Father's Name (| | | | | | | 18. Mother's Nan | | Maiden Sum | ama) | |
| 2 | d Mould | 2 | | | | | 10h Ma | Nine Address /6 | Name of | | ll Lane | or Ciby or Tou | n State 7i | Codel |
| Maryland 21215-0020 | and 2 s saith an 27 is 1 | | | Da. Informant's Name/Relationship (Type, Print) Kathryn D. Weddell - Wife 450 Poplar Leaf Driv | | | | | | | | | | 037 |
| e, | -IE6 | 1 | 20a. Method of Disp | position | | 20b. I | Place of Dis | position (Name rematory or other | of | n) - | Date | 20c. Location | n - City or To | own, Stata |
| Baltimore, | the fill the function of the f | | 4 Donation | ☐ Cremation 3 5 ☐ Other (Spec | ify) | State | | ematory | 7 | 1 | Teb. 17 2000 | Balti | more, | MD |
| Bal | Departiment Important Impo | | 21. Signature of FD | neral Seprice Lice | Monde | 1 | | | У | ss of Facility Funeral I y Avenue | | | D 214 | 401 |
| | | | 23a. Part1. Enter the shock, or hear | ne disease, or cor rt failure. List only | nplications that or | eused the deal | h. Do not e | | | | | | 1 | Approximata Intervat Between |
| | Physician /Medical | | Immediata Cause (| Final | (° 1901. | 1000 | 1, | hoc | - f | - da | Quas | | 1 | Onset and Death |
| B | Examiner | _ | disease or condition resulting in death) | п | . Cor | Due to (| or as a cons | equence of): | 7(| - far | | | 1 | |
| | bosh in an | Examiner | Conversion to the time | | b | Due to / | v se e cone | equence of): | | | | | 1 | |
| 90, | ificate be executed physician and as the burlatransit | | Sequentially list cor if any, leading to im- ceuse. Enter Unde Cause (Disease or that initiated events | mediate rlying | | 0.00 (0 (1 | n as a cons | 5455 617. | | | | | | |
| 68760, | physic the t | edical | that initiated events resulting in death) L | ast | · | Due to (c | r as a cons | equence of): | | | | | 1 | |
| | E 0.6 | | | | d | | | | | | | | i | |
| Box | attending for use a | clan | Part II. Other significant conditions contributing to death but not resulting in the underlying ca | | | | | | use given in Part I 23b. Did lobacco use contribute to the cause of death? | | | | | |
| 0 | the d ached | Physician/M | Part II. Other signifi | ()\a | contributing to de | ath but not res | ulting in the | underlying caus | se gw | en in Part I. | | Yea 2 No | | |
| 0. | ires that the death cert signed by the attendin d be detached for use | y P | Dia | weres | 147 | \sim | res | nal | | | | 100 2010 | 00110 | Salory Section 1 |
| Records, | The law requires that tha death cart its has been signed by the attending page 2 should be detached for usa it | Completed by | 100 500 | 1A. C.O. | la C. | | | | | | 24a. Was | an autopsy med? | 81 | ara autopsy findings vallable prior to |
| ecc | as be | ple | jongu | age we | nos | | | | | | | | of | ompletion of cause death? |
| E . | | 5 | (| | | | | | | | 10 | Vas 200 | 1 | ☐ Yas 2☐ No |
| Vital | shtiffe entiffe ector | Be | 25. Was case refarmaxaminer? | red to medical | Manakak | | | | Low | 26. Place of Dea | | | | |
| to | this of | 2 | 1 Yes 200 | | | • | ER/Outpat | | Oth | 4 LI Nursing H | | | | m HOSPICE |
| | After funer | - Lo | 27. Manner of Death 1- Natural | 5 Pending investigation | | of Injury h, Day Year) | 28b. Time Injury | M Zec | . Injur Wor | k? Yes 2 No | 28d. Ďescribe | now injury occ | urred | |
| Division | or Attending after death. Director: Afte in by the fune | fica | 2 ☐ Accident 3 ☐ Suicide | 6 Could not detarmined | be one Diese | of Injury - At h | ome, farm, | atreet, factory, o | | | | | nber or Rur | al Route Number, |
| S | Dire din b | Certification: | 4 Homicide | Getarriire | buildir | ng, etc. (Speci | y) | | | | City or To | wn, Stata) | | |
| | To the Hospital or Attanding Physitin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | edical C | 29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| | o the | ž | 29b. Signatura and | titla of certifier | See Trial | | | 29c. L | icens | e number | | 29d. Date sig | ned (Month, | Day, Year) |
| | ->-0 | | 119 | ma | 1. Or al | | | 1 | 12 | 476X | | 3/1 | 10 | 2 |
| | 10 | - | 30. Nama and addre | ess of person who | completed cause | of death (Iter | n 23a) (Typ | e, Print) | | | | | | |
| _ | 10 | | DABB | | n A | - | AAV | nc, | A | NNAPO | DLIS, | MD |) | |
| | Stat | | 31. Date filed (Mont | | | egistrar's Signi | ture 4 | Spa | | | | | | |
| | Registra | ar | FE | B T 8 50 | UU A | 700 | 10 | الما الما | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05020 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Genevieve C. Walter February 16, 2000 2:20 a.m. 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Lorien Frankford Nursing Center Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1□M 2ØF 78 217-12-3315 Baltimore, Md. Sept 4, 1921 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1X Yes 2 No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5205 Plainfield Avenue 21206 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 14. Rece - American Indien, 11. Merital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 10 Never Merried 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) U.S.Gov't Secretary 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony J. Walter Clara A. Walter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) 5205 Plainfield Avenue Baltimore, Maryland Alice M. Walter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 Cremetion 3 Removel from State 2/19/00 4 Donetion 5 Other (Specify) Holy Redeemer Cemetery Baltimore, Maryland 21. Signeture of Funeral Servica Licassee Milton J.Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 23a. Peri1. Enter the disease, or complications that caused the shock, or heart feiture. List only one cause on each line. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Intervel Betwe Onset end Death Immediate Cause (Finel diseese or condition resulting in death) rdupulmman arres Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Wheneschlivty Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Penahuai Vasulas / Certen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy my full will Repression 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? ~ 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury st Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident

Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760. use a þ Completed 89 Medical Certification: To this After

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

28e-f

8 must be

wazu amould be filed within 72 hours after de. Nasilto and Mental Hygiens. In 27 is marked other than "nature"

permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eve

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

P.O. Division of Vital Records, or Attending 24 hours after death. Funeral Director: A filled in by Hospital within 24 hor To the Fune completely fi To the

State Registrar

31. Dete tiled (Month, Day, Year)

6 Could not be determined

nammeto MI) Baltonne

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTHA

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

FEB 1 8 2000

29b. Signeture and title of certifier

3 ☐ Suicide

4 Homicide

(Check only one)

32. Registrer's Signature

Physician /Medical Examiner

Department of important: If any injury or

Physician

/Medical

Examiner

Director

Funerai

Completed by

Be

Md

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

8

Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic avent, or a Mark

death with the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

Examiner **burial-transit** and Physician/Medical the been signed by the attending should be detached for use by Completed certificate has page 2 funeral director, Be Medical Certification: To After this

or Attanding Physician: The law requires that the death certificate be executed death. 24 hours after deat Funeral Director; filled in by Hospital completely within 2 To the \$

Division of Vital Records, P.O. Box 68760

Jonathan Fish 31. Date filed (Month, Dey, Year) State Registrar FEB1 8 2000

27. Menner of Death

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture and title of certifier

s of person who completed cause of death (Item 23a) (Type, Print)

5 Pending Investigation

6 Could not be determined

3460 Ellicott Cutr. Dr. #103, Ellicott City MD 21043 32, Registrar's Signature

28a. Date of Injury (Month, Day Year)

1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

sach

28c. tnjury at Work?

1D Certifying Physictan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

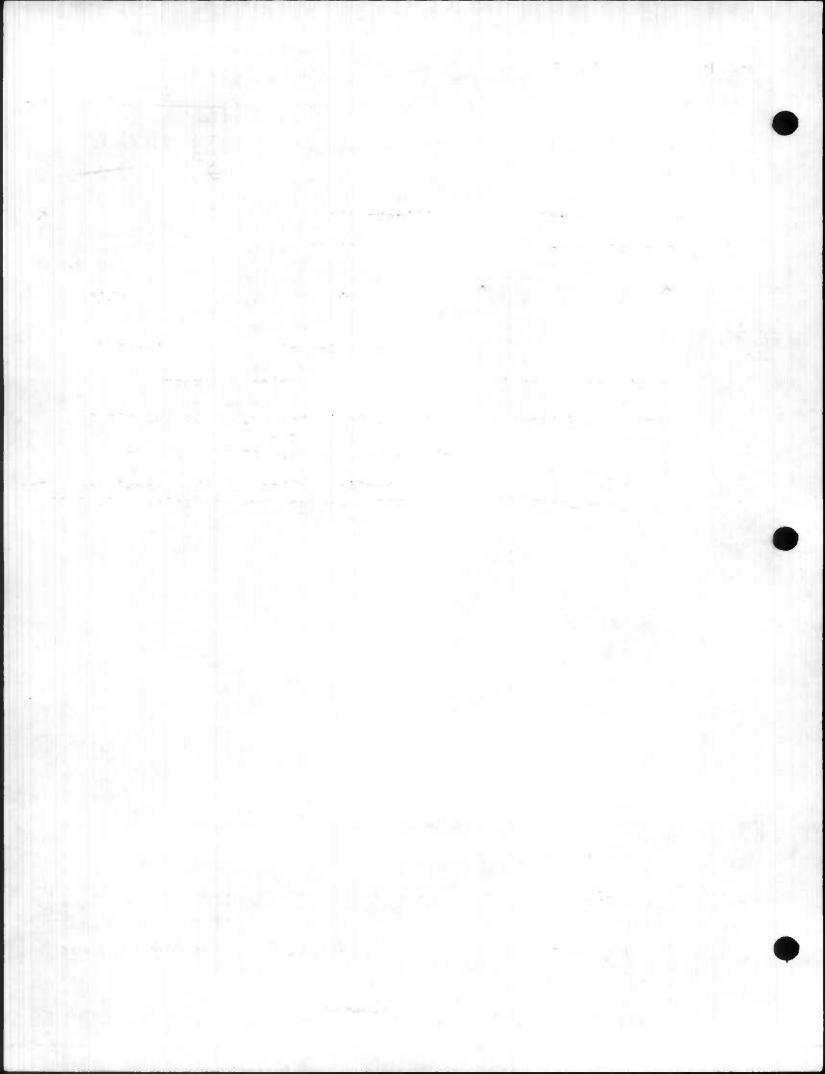
1 Yes 2 No

D51860

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item # 20b,23a,pt1,Line b,c,d, per Dr, G780,2718/Contificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Year MARY WHITE 2.50 AM JANUARY 2000 21 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CENTER HARBOR HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 M 2 A F 213-28-5173 -55-1920 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 108€ es 2 No Baltimpee WB NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Round 21225 403 Koad AZU VIEW 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates; 1 Never Merried 2 Merried Black 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HRIUPTE ILth PA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Washing NEWMAN MAUDE 10 KN JON . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Road Roundores 401 Dalto. Hd 21225 rasklis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 1-27/2000 METRO CREMATORY 22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 125200 BALTO. no of Funeral Service Licenses march Funeral Home West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Baito. Approximate Interval Between Onset end Deeth Immediate Cause (Finel RESPIRATORY FAILURE ACVTE 2 Hours disease or condition resulting in death) Due to (or as a consequence of): ZHOURS RATION Chronic Renal Failure Due to (or as a consequence of): ONE YEAR

Physician /Medical Examiner

physician and the burial-transit

U88 88 1

8

Certification

edical

State

Registrar

The law requires that the death certificate be assocuted

Box 68760.

P.O.

Division of Vital Records,

this

24 hour

To the P within 2 To the P

Daltim.
Department of the any injury or the once.

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

à

Completed

å

Funeral

Director

r than "natural", or hams 23a or 28a-f ahow the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after of the fact of Health and Mental by Hygiens. Intit I flam 27 Is marked other than "natural", or the ray or other traumatic avant, the health and the familia.

the Maryland

death

21215-0020

Baltimore, Maryland

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai á Completed

Due to (or as a consequence of):

MURE Diabetes Mellitus

10 YEARS 23b. Did tobacco use contributa to the causa of death?

1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. KYPO THERMIA

24a. Wes an autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2 No

1 1 Impatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospitel:

6 ☐ Could not be

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

29c. License number

3001

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

S. HANOVER STREET, BALTIMORE, MD 21225

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medicat Examiner: On the basis of examiner and manner stated. 29b. Signature end title of certifier

29a. Cartifier

27. Manner of Death

1 Netural

2 Accident

3 ☐ Suicide 4 Homicide

KESI DENT

29d. Dete signed (Month, Dey, Year)

laco 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INTERNAL MEDICINE

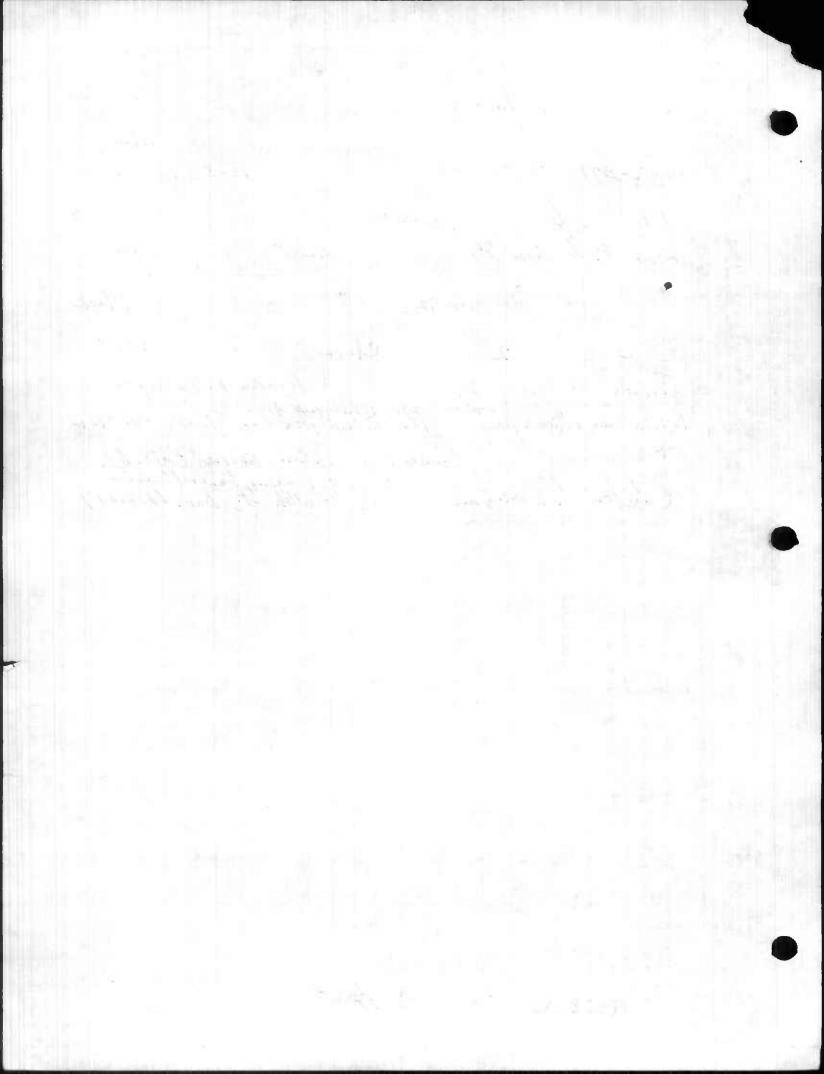
13 130

21 2000 JANUARY

BALASUBRAMANTAN

JAYACAKSHMZ FEB 1 8 2000 32. Registrar's Signature sacker

| December 1 term 23, 2, 7, 25a, 5, c, d, e, f. FPRINCIAD December 1 term 27 term 25 te | JAME: ASP | s pe | YANCEY er me G780 yg State of Maryland / Department of Health and | All Copies Mental Hy | Are Legil | ole. | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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| Physician Metical Examiner Part | amend | ite | em 23a,27, 28a,b,c,d,e,f, Certificate of Death | | | 00023 | | |
| Record Comment Comme | Physic | ian | | Month | Day | Year | | |
| ## Social | /Medi | ical | | | | | | |
| Director | Exami | ner | | | 10.000111 | 12 | | |
| Usual Residence of Decedert 100. Contry 100. Chr. Town or Location | | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. | . (Month, De | rth ay, Year) | 9. Birthplace (State or Foreign Country) | | |
| 1.1. Martial Status 1.2. Was Decodered Ever in U.S. 1.3. Was Decodered of Regards Origin? (Specify Year on Notifical Status 1.4. Facts - American Indian, 1.5. Facts | | | | 10-5 | 120 | Virginia | | |
| 11. Martial Status 12. Was Decoded Ever in U.S. 13. Was Decoded Origin? (Specify Yes on No-Black, Works, as: Specify 14. Rate-American Indian, Black 15. Was Decoded 15. Was Dec | Merylan a-f ahow | sctor | | | 10d. Inside City Limits 12SYes 2□No | | | |
| 1.1. Martial Status 1.2. Was Decodered Ever in U.S. 1.3. Was Decodered of Regards Origin? (Specify Year on Notifical Status 1.4. Facts - American Indian, 1.5. Facts | मूं क 28 | Dire | | | 10g. Citizen of V | What Country? | | |
| The Cive Specify Spe | £ 22 | ral | 7.52 | | U. | S.A. | | |
| The Course The | | nu | Armed Forces? If Yes specify Cuhan Meyican Puer | rto Rican, etc.) | | | | |
| Elementary/Secondary (0-12) College (1-4o-5+) College (1-4o-5 | | þ | | | | Dack | | |
| Physician Phys | | etec | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo | orking | 16b. Kind of Bu | siness/Industry | | |
| Physician Phys | villa then | Comp | Elementary/Secondary (0-12) College (1-4or 5+) | | D | MV | | |
| Physician The Beautiful Committee The Co | DE HOO | | 17. Father's Name (First, Middle, Last) 18. Mother's Ne | 1 | , Maiden Sumam | •) | | |
| Physician Phys | Venta by rked | 0 | James E. Yancey Sr. Kear | tha P. I | Veding. | ton | | |
| Physician Phys | Aar 2 sho 1 end 1 is me | | 19a. Informant's Neme/Reletionship (Type, Print) daughter 5 19b. Mailing Address (Street and Nymberor B | ural Route Numb | er, City or Town, | State, Zip Code) | | |
| Comparison Com | C 7 2 2 | | | Al. Date | 20c Location - | d. 2/2/5 City or Town State | | |
| Physician //Medical Examiner 23e. Part I: Enter the disease, or complications the Gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Consert and Death Physician of the mode of the conservation and the conservation are consequence of condition insularly in death) | nor of or | | 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) | L | P.11 | / A | | |
| Physician //Medical Examiner 23e. Part I: Enter the disease, or complications the Gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Consert and Death Physician of the mode of the conservation and the conservation are consequence of condition insularly in death) | of the later of th | | | 1 | 1800 | MI. | | |
| Physician //Medical Examiner Physic | W FOLLS | | Carlton C. Dougla. | ss fund | 11. hl | 21217 | | |
| Physician /Medical Examiner Medical Examiner | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock or head failure. List only one cause on each line. | ac or respiratory a | | Approximete | | |
| disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Eiter Underlying Cause Disease or limity that initiated events resulting in death) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy performed? 24b. Were autopsy finding available proving cause given in Part I. 25c. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25c. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25c. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25c. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25c. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25c. Manner of Death 1 Neutral 5 Pending 25c. Manner of Death 25c. Neutral | | | and the state of t | | | Onset and Death | | |
| Due to (or as a consequence of): Comparison of the constraint o | | | disease or condition . NARCUTIC AND ALCOHOL INTOXIC | ATION | | | | |
| Cause Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence | | 5 | | | | | | |
| Cause Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence | brid ansit | ulme | Sequentially list conditions Due to (or as a consequence of): | | - | | | |
| Description of the condition of the cond | 0 9 5 5 | | if any, leading to immediate | | | | | |
| Description of the state of the contribution o | 876 steep by short the by | dica | Inat initiated events | | | | | |
| Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other eignificant conditions contribute to the cause of death of the cause of death | X 6 | Me | d | | | | | |
| 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24b. Were autopsy finding available prior to so of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 X Yes 2 No 1 X Yes 2 No 25. Was case referred to medical examiner? 1 X Yes 2 No 25. Was case referred to medical examiner? 1 X Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 1 North A Nursing Home 5 X Residence 8 Other (Specify) 28. Date of Injury 28. Injury at Work? | Bo atte | clan | | 1 | | | | |
| 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24b. Were autopsy finding available prior to so of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 X Yes 2 No 26. Place of Death (Check only one) 27. Was case referred to medical examiner? 1 X Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? | O the state | hysi | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death | | | | |
| 24a. Was an autopsy performed? 24b. Were autopsy findia available prior to completion of cause of death? 1 | o det | y P | | . ' | 220100 | 5 Probably 4 Dillinow | | |
| 25. Was case referred to medical examiner? 1 (X) Yes 2 No 25. Was case referred to medical examiner? 1 (X) Yes 2 No 26. Place of Death (Check only one) 1 (X) Yes 2 No 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred Injury Work? | ords quire | 8 | | | | 24b. Were autopsy findings available prior to | | |
| 25. Was case referred to medical examiner? 10 Yes 2 No 25. Was case referred to medical examiner? 10 Yes 2 No 26. Place of Death (Check only one) 10 Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Nursing Home 5 No Residence 8 Other (Specify) 28c. Injury at Work? | B w re | plet | | | | completion of cause of death? | | |
| 25. Was case referred to medical examiner? 1 | | Com | | 100 | Yes 2□No | 1 Yes 2□ No | | |
| 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Injury Work? | /ita | Be | evaminer? | eath (Check only | one) | | | |
| □ P = 0 1 Netural 5 Pending f (Mopt/h]Day Year) Injury Work? | of hysical | | 1 inpatient 2 Envoutpatient 3 DOA 4 Nursing | - | | | | |
| 2 Accident 3 Suicide 4 Homlcide 4 Homlcide 4 Homlcide 5 5 5 5 5 5 5 5 5 | E & 8 4 | Hon | M 1 Vec 4 Table | | | 100 | | |
| building, etc. (Specify) found: home St., Baltimore City or Town, State) 2326 Eit Madi St., Baltimore City, iv St., Baltimore City, iv St., Baltimore City, iv Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. | /iSi | fica | 3 Suicide 6 Scould not be determined 28e. Place of Injury - At home, ferm, street, fectory, office | 28f. Location | (Street and Numb | per or Rural Route Number, | | |
| 29e. Certifier (Check only one) | din to the | le l | 4 Homicide building, etc. (Specify) | St. | Baltimo | 26 Eit Madiso | | |
| E C S G S S S S S S S S S S S S S S S S S | Hospita 24 hours Funera | dical (| 29e. Certifier (Check only (C | ce, and due to the | cause(s) and ma | inner as stated. | | |
| o € o 6 ≥ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | of the of the omple | ¥ | 29b. Signalure and title of certifier 29c. License number | | 29d. Date signe | d (Month, Day, Year) | | |
| O.C.M.E FEBRUARY 13,2000 | -240 | V | At M A Market un O.C.M.E | | FEBRUAR | Y 13,2000 | | |
| 30. Name and address of person who completed cause of death (Item 2011) (Type, Print) | M | 9 | 30. Name and address of person who completed cause of death (Item 2011 (Type, Print) | | | | | |
| Strphyn S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | CAN | | | , Baltim | ore, Mar | yland 21201 | | |
| State Registrar State 31. Date filled (Mourn Day Year) FEB 1 8 2000 32. Registra 2 Stoffature | | _ | 31. Date Hed (Month Ogy Yees) 2000 32. Registra (2000 Aparts) | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** February LINZ 6.35 P.M. 15 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c County of Deeth 4b. City, Town, or Location of Death Examiner Hopkins 6. sex 7. Age (In yrs. last birthday) The Johns BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) JUNE 18,1928 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 219-22-7002 1 ☐ M 2 💢 F Yrs. 71 MD Director Usuel Residence of Decedent the Maryland 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 77 is marked other than "natural", or flems 23s or 28s-f show trsumatic event, me Medical Examinar must be notified as 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's With 3507 ANTON FARMS ROAD 21208 U.S.A. Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Reca - American Indien, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 **HOMEMAKER** OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1
Department of Health and Mental 1
Important: If Item 27 is marked of
any injury or other traumatic eve **ABRAHAM** SAMUEL **GERBER** TESSIE GOODSTEIN 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 ANTON FARMS ROAD - BALTIMORE, MD 21208 HERBERT S. ZINZ / HUSBAND 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete BALTIMORE HEBREW CEMETERY 2/17/00 REISTERSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility 21. Signeture of Funeral Service Licenses SOL LEVINSON & BROS., INC. eurs 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 in, or complete us that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, that only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical three weeks Examiner Due to (or as e consequence of): Physician/Medical Examiner two weeks 9e MIA sician and burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician s the burial The law requires that the death certificate Due to (or as a consequence of) US0 83 Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown ScleroderMA Records. by sign. 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy hydrove phrosis performed' 2 No 1 Yes 2 No 1 Yes liary obstruction certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this funeral 28a. Dete of tnjury (Month, Day Year) 27. Menger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending s sfter death.

I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Kes - 000 15,2000 ebruary d cause of death (Item 23a) (Type, Print) 30. Neme and ress of parson who complet Johns Hopkins Wolfe Martin 600 North

DHMH 16 Rev 6/95

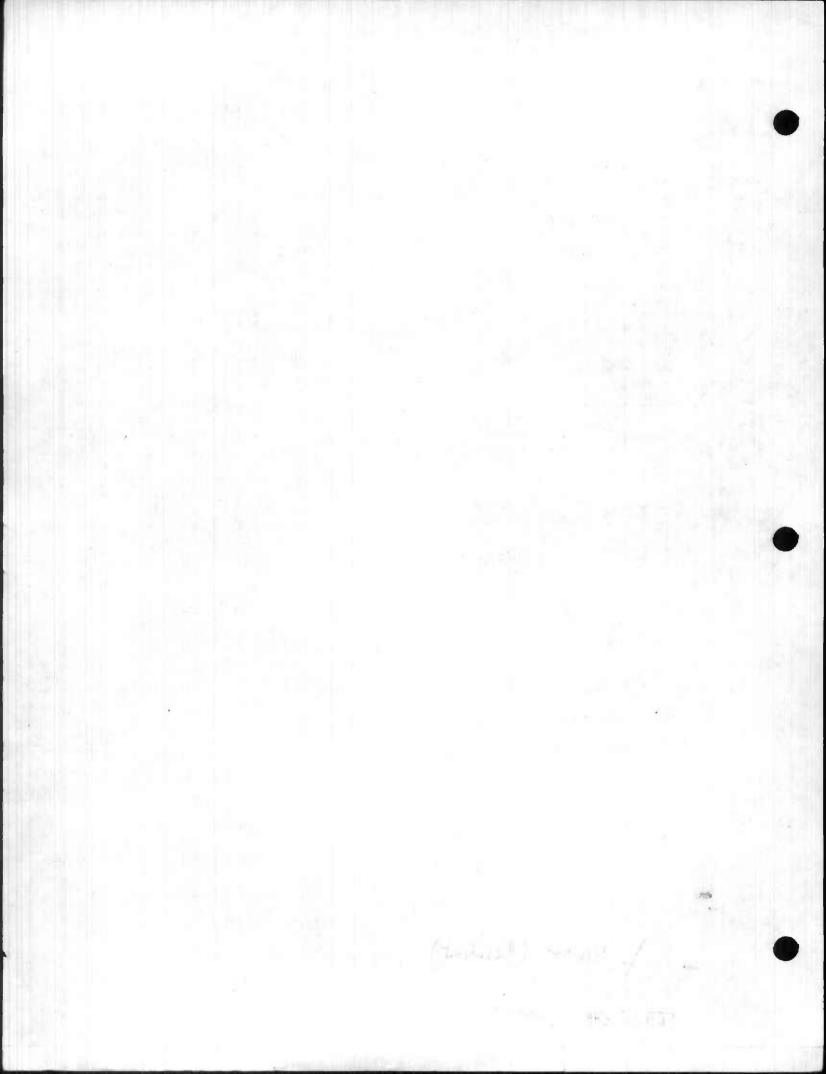
State

Registrar

31. Data filed (Month, Dey, Year)

FEB 1 8 2000

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| 9 | n | 0 | 0 | 5 | 0 | 2 | 1 |
|----|---|---|---|---|---|---|---|
| 3. | 0 | U | U | U | U | 4 | 9 |

| | Physician /Medical Examiner |
|---|-----------------------------------|
| _ | Funeral |

SUFTA 4a Fecility Name (If not institution, giva street and number)

1. Decedant's Name (First, Middla, Last)

Month 1-22-2000 4b. City. Town, or Location of Death

3. Time of Death 9:48pm

6316 Gentle Light La. 5. Social Security Number 10M 20F 57

Columbia If Under 1 Yaar If Under 24 Hrs. 7. Age (In vrs. last birthday) Days

10f. Zip Code

Months

Howard

4c. County of Death

Director

Usual Rasidence of Decedant 10a Stata 10b. County

220-17-5308

10c. City. Town or Location

Columbia

AMIN

8. Date of Birth (Month, Day, Ye 2-22-42

2. Deta of Death

 Birthpleca (State or Foreign Country) Bangladesh

10d. Inside City Limits

1 Yas 2 No

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exempter. Funeral Director Completed by

Be

Maryland Howard 10e Street and Number 6316 Gentle Light La. 1 Nevar Marriad 2 Married

12. Wes Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 21X No If Yas, Giva Year or Dates

21044 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yas 2 No Specify:

Hours

USA 14. Race - American Indian, Black White, etc. Specify: Asian

15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

10g. Citizen of What Country?

17. Fethar's Nama (First, Middla, Last)

3 ☐ Widowed 4 ☐ Divorced

Day Care Provider 18 Mother's Nema /First Middle Maiden Sumama

Day Care

Mohammad Abu Bakar

19e. Informant's Neme/Raletlonship (Type, Print)

Mehrunnessa Bakar 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Shahina Bashir-Daughter

20b. Place of Disposition (Nama of cematery, crematory or other place)

20320 Watkins Meadow Dr. Germantown, Md. 20876 20c. Location - City or Town, Steta

20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify)

George Wash. Cemetery 1-23-2000 Adelphi, Md.

21. Signature of Funaral Sarvice Licensee 23a. Pert1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or haart feitura. List only ona causa on aach line.

22. Nama end Address of Facility Universal Mortuary Inc. 411 Kennedy St, N.W., Washington, D.C.

Date

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

and

physician

signed by the a d be detached f

Deen

has

certificate

this funeral

After

death.

after death Director: A d in by the f

To the Hospital within 24 hours a To the Funeral Completely filled Hospital 24 hours a

director,

filled in by

the

The law requires that the death certificate be executed

Box 68760.

D.O.

Division of Vital Records,

Attending Physician:

Immediata Causa (Finel disaase or condition rasulting in death)

eiomyosorcoma Dua to (or es e consequence of

Approximate Intarval Between Onset and Death

Sequentially list conditions, if eny, laading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Lest

Dua to (or es e consequence of)

Dua to (or as a consequence of)

Part II. Other alonificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

24b. Were eutopsy findings eveilable prior to completion of cause of death?

3 Probably 4 Unknown

1 ☐ Yes 2X No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes casa rafarred to medical examinar? 1 Yas 2 No

5 Pending investigation

6 Could not be datarmined

Hospitel: 1 | Inpatient 28a. Deta of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury et Work?

1 Yes 2 No

Other: 4 Nursing Horna 5 Residence 6 Othar (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Certifier (Check only one)

27. Mennar of Deeth

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

MAPA

29c. License number

29d. Data signed (Month, Day, Year) Hospital, 600 N. Wolfe St., Baltimore, MD 21287

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Nark G. Frattini, M. D., Ph. D., Johns Hapkins

State Registrar 31. Deta filed (Month, Day, Year) JAN 3 1 2000

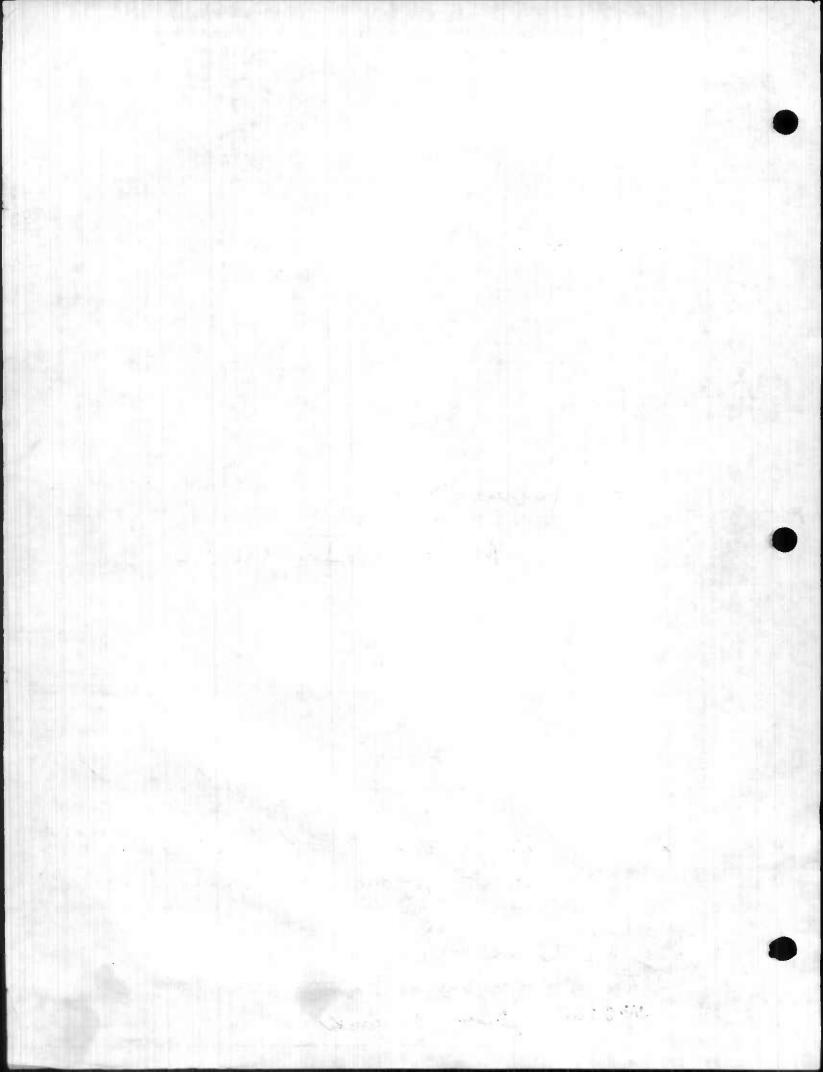
28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

Some the sound

JAN 5 1 2000

| ile. | - | 0 | 0 | 0 |
|------|---|---|---|---|
| 0 | C | U | 6 | 0 |

| | 1. Decedent's Name (First, Middle, Last) | ificate of Death | Reg. No. | 3. Time of Death |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physiciar | Catherine W. Armstrong | | Month Day Year January 24 2000 | |
| /Medica Examine | An English blanch of the and to a think the annual and the annual annual and the annual | 4b. City, Town, or Loc | | |
| | Doctors Community Hospital | Lanham | Prince (| George's |
| • Funeral Director | 579-28-1079 1□M X□F 73 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 26, 1926 | rthplace (State or Foreign ountry) P.G. |
| show after | Usual Residence of Decedent 10a, State 10c. City, Town or Loca Lanham | tion | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| after death with the Maryland or Items 23a or 28e-f show union must be notified at | 10e, Street and Number 9805 Good Luck Road | 101. Zip Code 20706 | 10g. Citizen of What C U . S . A | Country? |
| 5-0020 72 hours after death v natural, or frame 23s steal Examiner most | 3 Widowed 4 Divorced Yaar or Dates: NO | as Decedent of Hispanic Origin? (Speres, specify Cuban, Mexican, Puerto F | city Yes or No- Rican, etc.) 14. Raca - An Black, Wr Specity: B.] | |
| 121 within then the Me | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottega (1-4or 5+) 12 | nt's Usual Occupation nd of work done during most of workin D NOT use retired) LOTY Managemen Specialis | t Office | ent Printin |
| yland 2 Just be filed Mental Hygin ricked other attic event, il | 17. Father's Name (First, Middle, Last) Mack Williams | | | |
| | 19s. Informant's Name/Relationship (Type, Print) Samuel Armstrong 19b. Mailing 9805 | Address (Street and Number or Rural Good Luck Roa | d Lanham, Mary | land20706 |
| Baltimore, semil. Pages 1 at Separtment of Hea reportant if Item; iny injury or other ance. | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | tion (Name of topy or other place) Memorial Park | Feb. 1, 2000 Lar | ndover, Md. |
| Ball permit Depart impoort any in | | Name and Address of Facility Dbinson Funeral 113 6th St. N.W | Home Washingt | con, D.C. |
| Physician /Medical Examiner | 23a. Pand Pater the disease, or complications that caused the death. Do not enter show or heart failure. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) Dua to (or as a confequence of the condition resulting in death) | e Inju | ries | Approximate the state of the st |
| Box 68760, leath certificate be axecuted attending physician and for use as the burial-transit | Cause (Disease or Injury that initiated events pue to (or as a consequence resulting In death) Last | | | |
| P.O. nat the d by the setached | | erlying cause given in Part I. | 23b. Did tobacco use contribu | tis to the cause of death? Probably 4 Unknown |
| aw requires to been signification to should be | | | 24a. Was an autopsy performed? | o. Wara autopsy findings available prior to completion of cause of death? |
| - F # 2 2 | | | 112 Yes 2□No | 1 □Yas 2 □ No |
| of Vital Physician: The this certificate ral director, par | examinar? | 26. Place of Death | | |
| After fune | A CONTRACTOR OF THE PROPERTY O | 28c. Injury at Work? M 1 Yes 2 No | ne 5 Residence 6 Other (St. 28d. Describe how injury occurred Driver Color (St. 28d. Location (Street and Number or City or Town, State) | - rehicle h Bus |
| DIVISION TO THE HOSPITAL OF ARTHUR TO THE HOSPITAL OF THE PURPLE OF THE | 29a. Certifier (Check only one) 1 Certifying Physician: To tha best of my knowledge, death of the control one) 2 Medical Examiner: On the basis of axamination and/or investant and manner stated. | thence and Good L occurred at the time, data and place, a stigation, in my opinion, daath occurre | uck Road; Collind due to the causers) and manner | SePark, M as Italed. ua to tha causa(s) |
| To the state of th | 29b. Signature and titla-al certifier | 29c, License number | 29d. Date signed (Mo. | nth, Day, Year) |
| (In) | 30. Name and address of person who completes cause of peath (Itam 23a) (Type, Pr | O.C.M.E. | January | 29, 2000 |
| State | 31. Date 1 of (Month, Day, Yeal) 32. Registrar's Signature | Penn Street, Balt | imore, Maryland 2 | 1201 |
| Registra | 1000 to 1000 to 1000 | 1.5. | | 455 4 5 |



Please Type or Print in Black Indeiibie Ink. Assure All Copies Are Legible. 5 0 2

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Data of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month **Physician** January 28, 2000 Edward J. Allen 2:30 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery if Undar 24 Hrs. 8. Data of Birth (Month, Day Year) October 24,1916 5. Social Sacurity Number If Undar 1 Year 9. Birthplace (State or Foraign Country) Canada 6 Say 7. Aga (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days 83 212-98-0015 Director Usual Residence of Decedant the Maryland 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 and theath and Mental Hygiene. marked other than "naturel", or items 23s or matic event, the Medical Examiner must be a 14400 Homecrest Road 20906 Canada Funeral 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Operater Pipeline 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Name (First, Middla, Last) Edward J. Allen Minnie Entwistle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Ralationship (Type, Print) Edward Dale Allen/ Son 10428 50th St. Edmonston, Alberta Canda T6A2C6 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, cramatory or other place) Data 20c. Location - City or Town, Stata XX Burial 2 Cramation 3 Ramoval from Stata Ft. Lincoln Cemetery February 3,2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Ft. Lincoln Funeral Home Signature of Funeral Service License 3401 Bladensburg Rd. Brentwood, MD 20722 erbo se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician Respiratory Failure /Medical Immediate Cause /Final disease or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performer? completion of cause of death? page 2 89 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To † □ Yes 2 ☐ ER/Outpetient 3 ☐ DOA 27. Maryer of Deal 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending P
 Fours after death.
 Funeral Director: After 1 Matural 5 Pending 2 [] Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

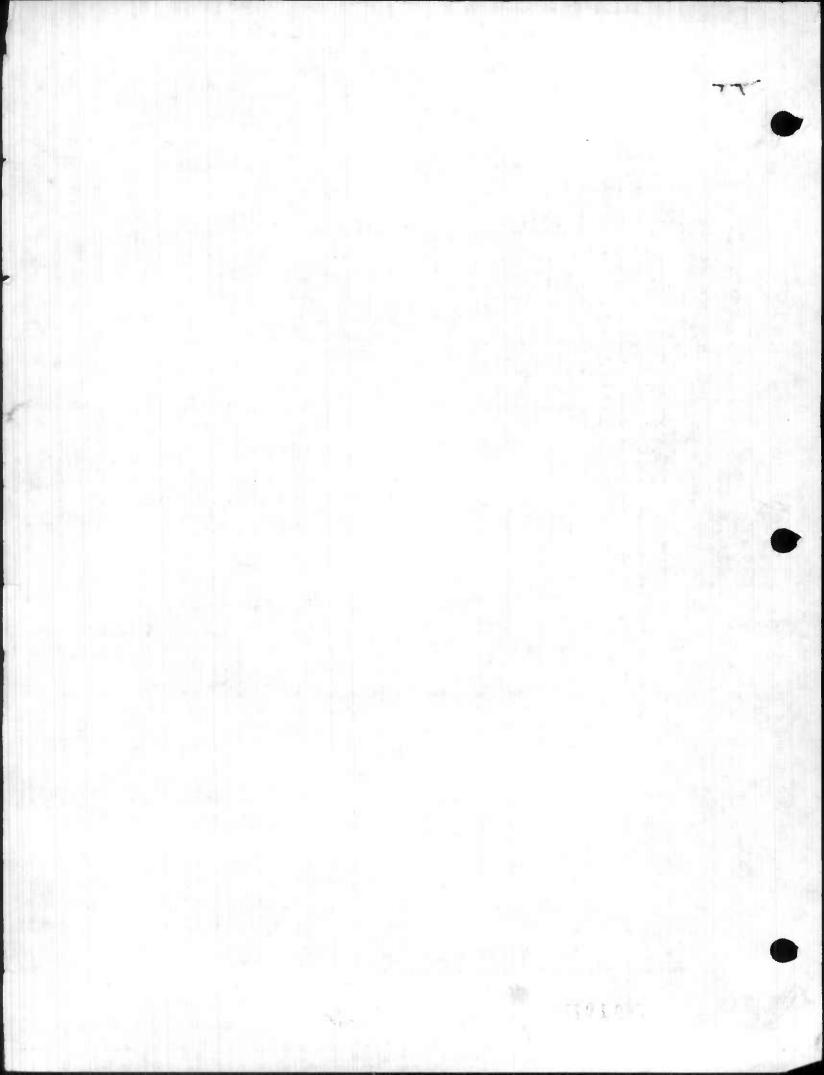
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. 29a Certifier Medical To the within 2 To the P 29bcSignature any fittle of gertifier 29c. License number 29d, Data signed (Month, Dav. Year) and addless of person why complated causa of death (from 23a) (Type, Print) 18111 PRINCE Phillip Drive Olne, Marykin 20855 31. Date filed (Month, Day, Year)

State Registrar

FEB 0 2 2000

32. Ragistrar's Signatura

100 5 0 83



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Year

1. Decedent's Neme (First, Middle, Last) Month **Physician** Holam 5 0-SEdONIA 79 /Medical 4e, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA INM Convalescent Baltimore If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1□M 25F 0 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location r 28a-f show Director TINION 10a Street and Number 10g. Citizen of What Country? 6 USA 14. Rece - American Indian, Black, White, etc. Narra 23a Funeral permit. Pages 1 and 2 should be fried within 72 hours after dea. Department of Health and Mental Hygerre. Important if Item 27 is marked other than "nature any injury or other traumatic. 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 1 Never Merried 2 Merried 1□ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 Never Worked Never Worked 17. Father's Neme (First, Middle, Last) 16. Mother's Neme (First, Middle, Meiden Surname) Be 4dams 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) Sampson Hurlock, Maryland 21643 661 Margaret niece 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Washington Cemetery Hurlock, Md 21. Signeture of Funeral Secreta Licensee 22. Name end Address of Facility
Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Myocardial Infraction /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner bo cyto physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last P.O. Box 68760. Due to (or es a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

Physician/Medical Be Completed by

 Mospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical eleby filled in by the funeral director; p. Medical Certification: To

25. Wes case referred to medical

Records,

Division of Vital

24a. Wes an autopsy performed?

1 Yes ANO 3 Probably 4 ☐ Unknown

00

9. Birthplace (State or Foreign Country) tone CO

IACK

10d. Inside City Limits

1 Yes 2 No

1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

Junua of

26. Placa of Deeth (Check only one)

Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Metural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

6 ☐ Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

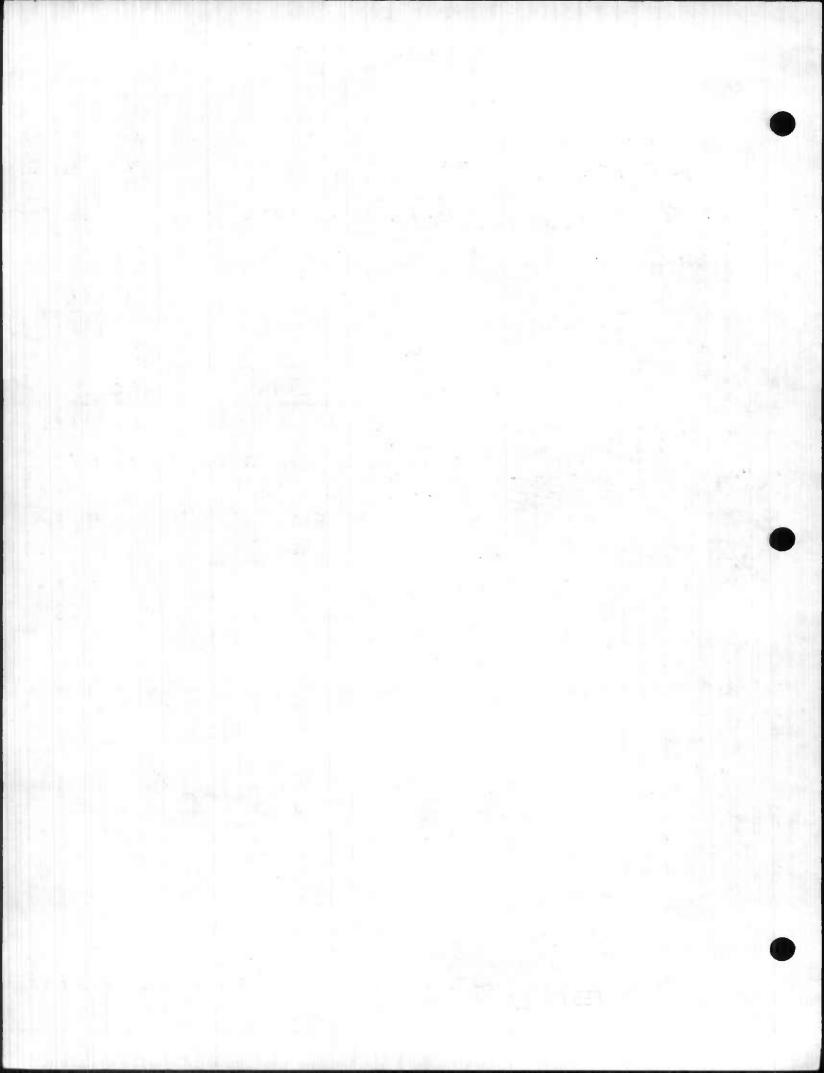
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted. 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 2006 Registrate Signeture Postal Suite 102, Pasadenia, Md. 2 1122 mer

State Registrar

To the Vithin 2



Please Type or Print in Black indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month January 19, 2000 Bruce F. 2145 Archer, Jr. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day, Year) Sept. 23, 1919 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Months Days 1 M 2 □ F 80 Yrs. 428-01-2336 Mississipppi Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Harford Aberdeen 1 Yes 2 No 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 432 Doris Circle 21001 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give ⊿ 1 Nevar Married 2/2 Married 1 ☐ Yes 2 No Specify: Yaar or Dates: 42-62 Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Military 12 U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Bruce F. Archer, Sr. Ada Pervis 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Hazel S. Archer (Spouse) 432 Doris Circle, Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 2/1/00 Burial 2 □ Cremation 3 □ Removal from State Arlington, Virginia Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 21. Signature of Fuperel Service Licensea 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to the Dua to (or es a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 YUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 M No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

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therma.

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Hygiene.

Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve Pages 1 and 2 should be

must be notified at

Director

Funeral

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Completed

Be

MD

death with the Maryland

filed within 72 hours after

21215-0020

Maryland

Baltimore,

use as the burial-tran 3 8 has cartificate this

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Division of Vital Records,

Physician/Medical Examiner à Completed Be Certification: To After

Attending Physician: The law requires that the death filled in by the funeral director, death. or Attendation of the order of To the Hospital o within 24 hours aff To the Funeral Di

0+1

State Registrar

Medical

29e. Certifier

1 Yes 2□ No

27. Menney of Death

1 Divetural

2 Accident

3 Suicide

4 Homloide

29b. Signature and Mile of certifier

31. Date filed (Month, Dey, Year) JAN 2 4 2000

Hospitel: Inpatient

5 Panding investigation 6 Could not be determined

28e. Dete of Injury (Month, Day Year)

28e. Pleca of Injury - At home, term, street, fectory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Tima of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 Yes 2 No

28d. Describe how tnjury occurred

Grace, md. 21078

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

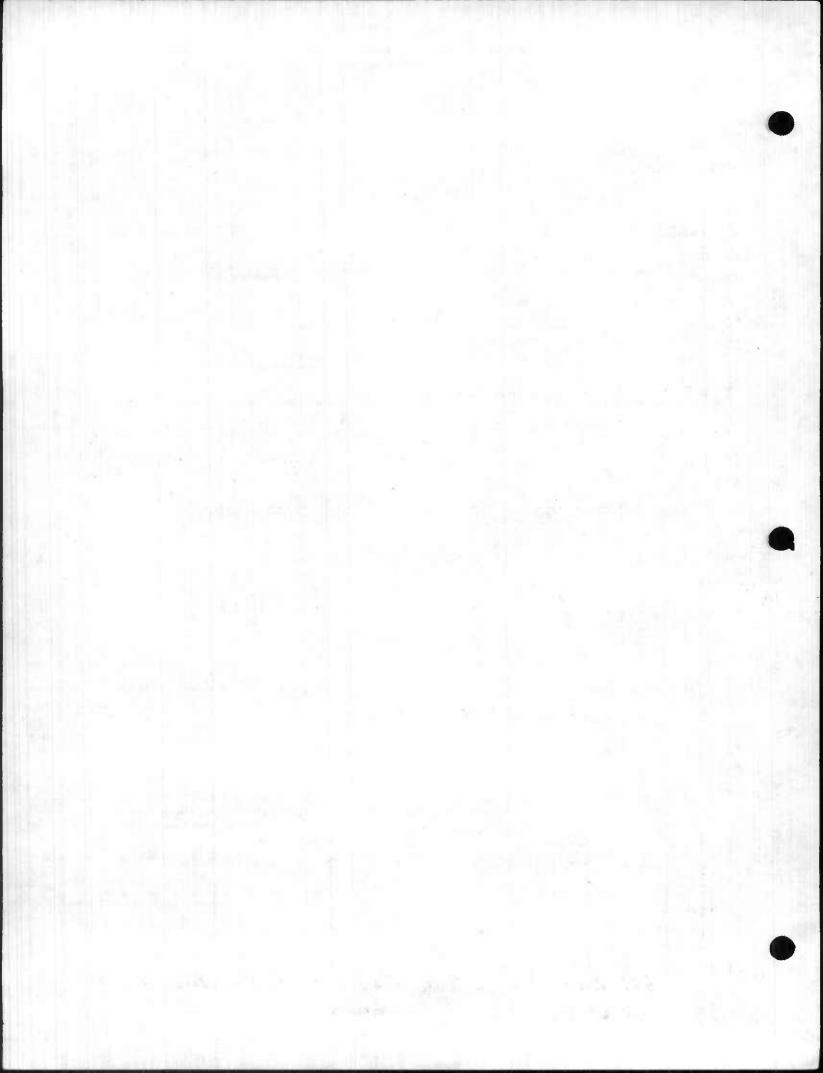
28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

29c. License number

29d. Data signed (Month, Day, Year) 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

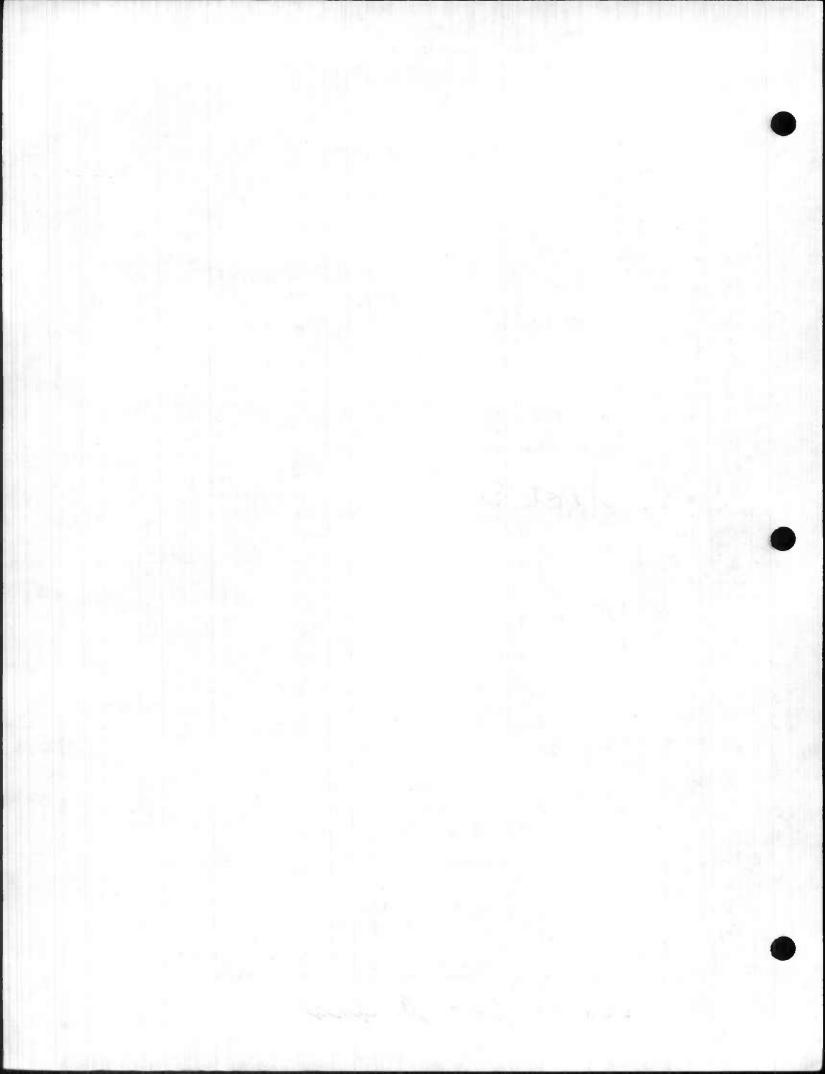
ave Douth LOW 62. Registrar's Signature



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| State of Maryland / Department of Health and Mental Hygiene [| 0503 |
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| | | | | | | Ce | rtificate o | f Death | | | Reg. No. | | | |
|----------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------|------------------------------|---------------------------------|---------------------------------------------------|--|
| П | | | 1. Decedent's Name (First, Middla, L | sst) | | | | | | 2. Data of Dea | ath Day | Year | 3. Time of Death | |
| d | Physicia /Medic | _ | DOROTHY LOU | ISE APP | ERSON | | | | | FEBRUA | | 2000 | 1:34AM | |
| | Examin | | 4a Facility Name (If not institution, g | ve street and number) | | | | 4b. City, To | wn, or Lo | ocation of Death | 4c. Co | unty of Death | | |
| | D ₁ | | 9100 BAYSIDE AVE | - | | a de l'adde ada co | If Under 1 Yes | NORTH or If Under | | | - | VERT | place (State or Foreign | |
| | Funeral Director | | 579-56-0742 Usual Rasidence of Decedent | 1 M 2 M F | e (In yrs. las | Yrs. | Months Day | | Min. | 8. Date of Birt (Month, Da) JAN 9 | nth, Day, Year) Country) | | | |
| | ytan | | 10a. Stata 10b. County | | 10c. City, 7 | Town or L | ocation | | | | | | 10d. Inside City Limits | |
| | after death with the Maryla or Neme 23s or 28s-1 shor uniner must be notified at | ctor | MARYLAND CALVER | [| NORT | H BE | ACH | | | | | | 1 ☐ Yas 2 ☐ No | |
| | E 20 E | Directo | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen | of What Cou | ntry? | |
| | 23 a | | 9100 BAYSIDE AVE | TUE NUMBER | 206 | | 2071 | 4 | | | | S. A. | | |
| | Pr de | Funeral | 11. Marital Status | Armed Forces? | 12. Was Decedent Evar in U.S. Armed Forces? 1 □ Yas 2 ☑ No 1 ∀es, Give Year or Datas: 13. Was Dece If Yes, spe 1 □ Yes | | | Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et | | | | Race - Americ Black, White, | | |
| 21215-0020 | 72 hours after natural, or hi dical Examin | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | If Yes, Give | | | | o Specify: | | | Spi | ecity: WH] | ITE | |
| Š | "natural", edical Exa | etec | 15. Decedent's E (Specify only highest g | | ducation 1 | | | upation e during mos | t of work | ing | | of Business/In | | |
| 121 | iene. Iban | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | | life. | DO NOT use reti | red) | | | | | ADEMY OF | |
| 92 | 2 2 2 2 | ပိ | 12 17. Father's Name (First, Middle, Las | t) | | PRODU | OCTION M | | | e (First, Middle, | SCIEN Maiden Sur | | | |
| an | Mental Mental rked or fic eve | o Be | HERMAN KUEHNE | * | | | | | | ELLE BI | | | | |
| Maryland | M P M | 2 | 19e. Informant's Neme/Retetionship | (Type, Print) | | 19b. Meil | ing Address (Stre | | | | | own, Stata, Zij | o Code) | |
| | alth an 27 is r | | DONNA M. BRADY / | DAUGHTER | | 7634 | OLD BAY | SIDE R | OAD (| CHESAPE | AKE BI | E BEACH, MD 20732 | | |
| ore | of He of He Mem | | 20a. Method of Disposition 1 Durial 2 Cremation 3 | Damausi from State | 20b. Plac | e of Disp | osition (Name of matory or other p | lace) | | FEB* | 20c. Locati | ion - City or T | own, State | |
| Ĕ | artment of pertant: If injury or | | 4 Donation 5 Other (Spec | fy) | LEE | CRE | MATORY | | 8 | ,2000 | CLINI | TON, MA | ARYLAND | |
| Baltimore, | permit. Page Department of Important: If any Injury or SISSE. | | 21. Signature of Funeral Service Lice | ansee T | | | 2. Nama and Add | | LE | | | | /ERT,P.A. //D 20736 | |
| | | | 23a. Party. Enter the disease, or conshock, or heart failure. List ont | nplications that aused | the death. | | | | | | | LIVOD, I | Approximate Interval Between | |
| | Physician / /Medical Examiner | | Immediate Ceuse (Finel disease or condition | M- | tast | , | | | | ance | | | Onset and Death | |
| | | ner | rasulting in death) | | Due to (or e | | | J | | 7, 61 | | | | |
| | cate be exacuted physician and s the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | 0. | Due to (or e | s a conse | quence of): | | | | | | | |
| 68760, | sician buria | ie E | Cause (Disease or injury | | | | | | | | | i | | |
| | rifficate be exacuted ng physician and as the bural-transit | Medic | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | |
| Вох | | | | d | | | | | | | | 1 | | |
| 0. | e des the at hed fo | sici | Part It. Other significant conditions | contributing to death be | ut not resulti | ng in the | underlying cause | given in Part | 1. | 23b. Dld 1 | lobacco use | contribute t | o the cause of death? | |
| . P.O. | v requires that the death been signed by the atte should be detached for | Completed by Physician/ | Endstag | c Clas | 11 | Obs | Luctio | c | | 10 | Yee 2 8 | No A Pro | bably 4 Unknown | |
| ds | uires n sign | ם ע | , | | à | | | | | 24e. Was en eutopsy 24b. Were autopsy findin- | | | | |
| 000 | Physician: The law requires that this certificate has been signed by this director, page 2 should be detent | Sete | Pula | ionary | Vise | 45C | | | | perfo | rmed? | CC | vailable prior to ompletion of cause death? | |
| 2 | he lav | Eo | | | | | | | | 101 | ras 2000 | | ☐Yes → No | |
| ta | delan: The | BeC | 25. Was case referred to medical | | | | | 26. Place | e of Deat | h (Check only o | , | | | |
| > | yalci is cer direc | 2 | axaminer? | Hospitel: | nt 2 EF | ?/Outpatie | nt 3 DOA | When | | me - Resid | | Other (Speci | fy) | |
| Division of Vital Records, | ang Ph. After thi funeral | Certification: | 27. Menner of Death 1 Natural 5 Pending investigation | 28a. Dete of Injur (Month, Day | Year) 28 | 3b. Time of Injury | W | jury at /ork? □ Yes 2 □ | | 28d. Describe I | now injury or | ccurred | | |
| /ISI | Attending or death. | fica | 3 Suicide 6 Could not | oe on the office | Jry - At home | e, ferm, si | reet, fectory, offic | | | 28t. Location (S | Street and N | lumber or Rur | al Route Number, | |
| ă | al or A after Direct d in by | E | 4 Homicide | building, etc | | | | | | City or Tov | vn, State) | | | |
| | Hospi 24 hou Funer Funer ptely fill | edical | 29e. Certifier Check only and Medical Exa | hysician: To the best of miner: On the basis of and menner ste | examination | edge, deel n and/or in | th occurred et the evestigation, in m | time, date ar y opinion, dee | nd place, eth occurr | and due to the ed at the time, | cause(s) and date and pla | d mannar es s ice, end due l | stated. to the cause(s) | |
| | To the | Me | 29b. Signature and title of certifier | 1111 | | | 29c. Lice | nse number | | | 29d. Date si | igned (Month, | Day, Year) | |
| | 10 | | - | 1/1/4 | 1 | | | 122 | 17- | 3 | 7. | 5. Or. |) | |
| | (W) | 1 | 30. Name and address of person who | | | | | | | | | | | |
| | 7-1 | | JONATHAN LOWENTHA | - | | | DERICK, | MARYLA | ND : | 20678 | | | | |
| | Stat Registra | | 31. Date filed (Month, Day, Year) FEB 0 7 20 | | ar's Signatur | · 19. | Span | 6 | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 10:50 A.M. February 3, 2000 Geraldine Addison 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 231 Bloomsbury Avenue Havre de Grace Harfor 1 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Months Hours Devs 1 M 2CX July 23, 1937 386-36-0896 62 Kentucky Usual Residenca of Decaden 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits XX Yes 2 No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 231 Bloomsbury Avenue 21078 U.S.A. 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Meat Cutter Grocery Store 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Avery E. White Mary Alice Cane 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Gischel (Daughter) 226 Bloomsbury Avenue, Havre de Grace, MD 21078 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Purial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gardens 2/7/00 Aberdeen, Maryland 21. Signature of Funerel Servica Licansee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21001-3399 Aberdeen, Maryland mplications that cause it the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, by one cluse on each time. 23a. Part 1. Enter the disease, or comshock, or heert feilure. List only Approximete Interval Between Onset and Death Immediate Cause (Finel ASCVD disease or condition resulting in death) Due to (or es e consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequenca of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending 1 Natural 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Examiner physician end the buriel-transit that the death certificate be executed Box 68760 signed by the e O σ. Records, requires peeu s certificate has b The law Division of Vital Hospital or Attending Physician: director, this funeral Affer s after dec.

in 24 hour. the Funeral Director in the fulled in within 24 hox To the Fune completely li

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show

I is marked other than "natur traumatic event, the Medical

Peges 1 and 2 should be file ment of Health and Mentel Hi ant: If item 27 Is marked oth

permit. Peges Department of important: If It any injury or o

Physician /Medical

Baltimore,

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

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2

Certification:

Medical

4 Homlcide

(Check only one)

31. Date filed (Month, Day, Yeer)

FEB 7

29a. Certifier

MD

filed within 72 hours after death with the Marylend Hygiene.

State Registrar

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

MO

29b. Signature and title of certifier

2000

OME

29c. License number

29d. Date signed (Month, Dey, Year) 2000

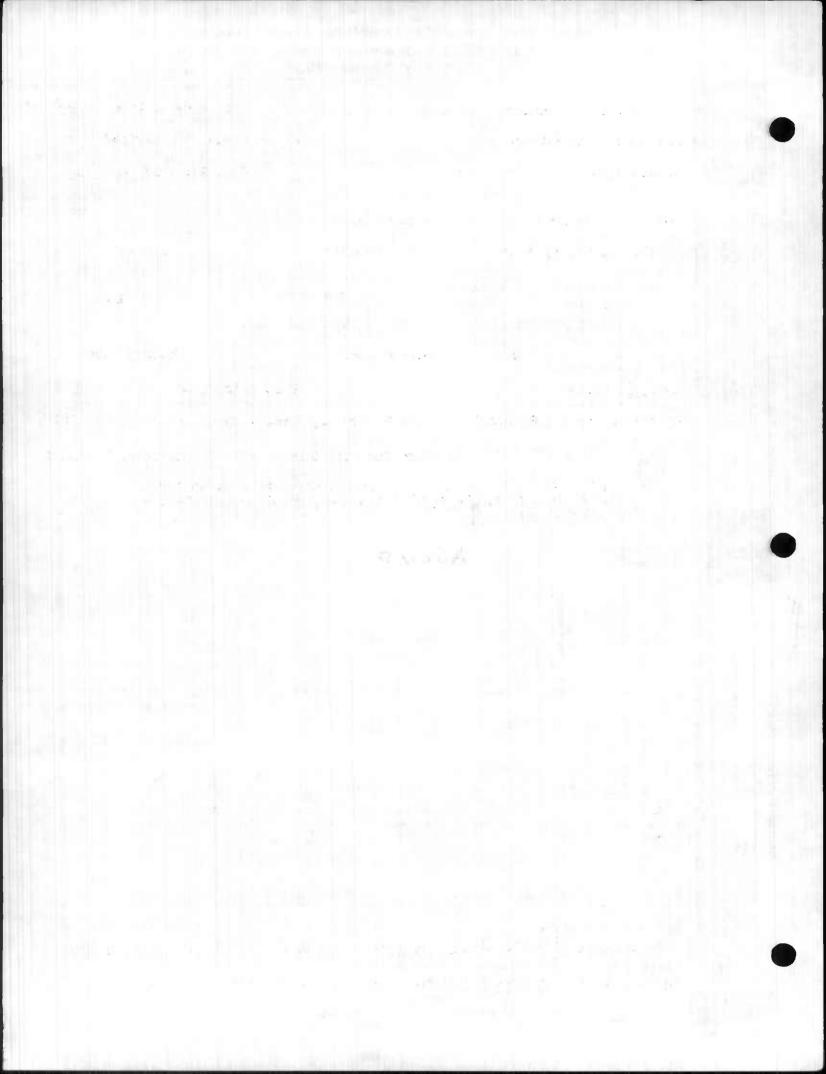
21014

and address of person who completed cause of death (Item 23a) (Type, Print)

NASH MM

Registrar's Signature

the



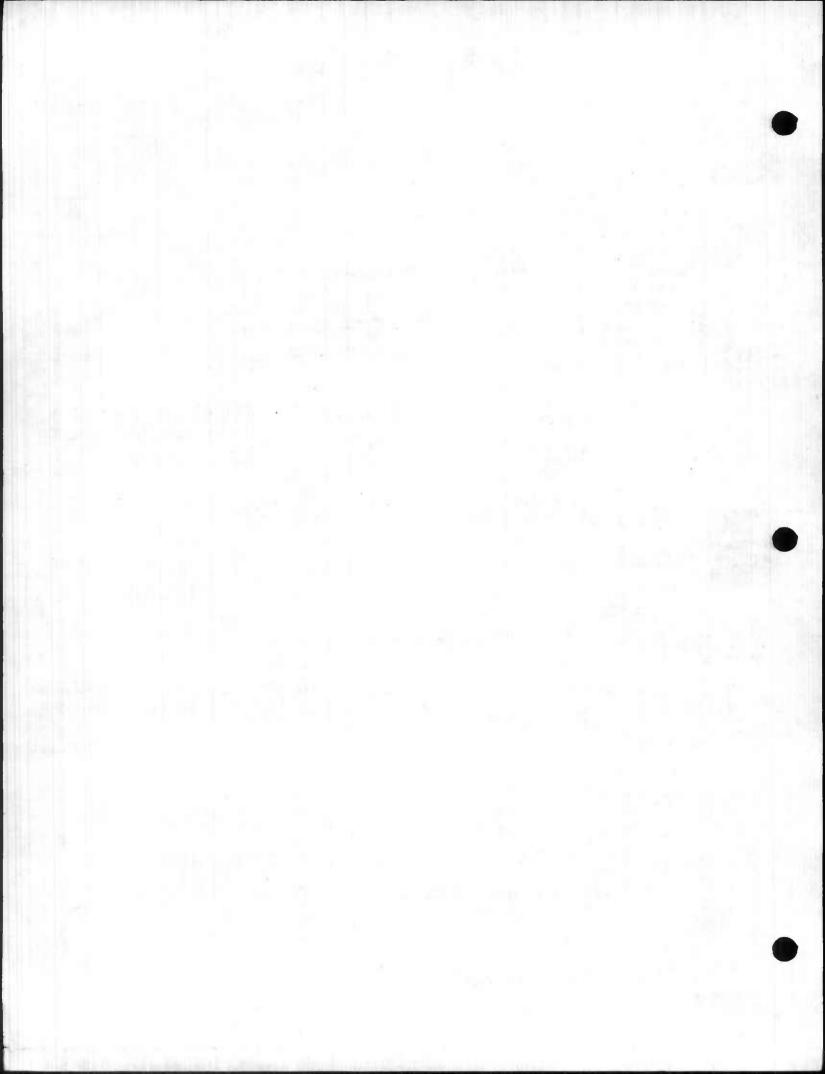
Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 3 3

Certificate of Death

Reg. No.

| | | | | | | | Cer | tificat | e of | Death | | Re | g. No. | | 000 | O |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------|--------------------------|------------------------|--------------|------------------------------|-------------------------------------------------|------------------------------------------|--------------------------------------------|-----------------------------|----------------------------------------------------------------|-----------------------------------------|
| | | | 1. Decedent's Neme | (First, Middle, | Last) | | | | | | | 2. Date of Deat | h | | 3. Time of | Death |
| | Physicia | | Joseph | John | Braun | | | | | | | Jan. | 25, | 2000 | 9:20 | AM |
| | /Medica Examine | | | | give street end number |) | | | | 4b. City, To | wn, or L | ocation of Death | 1 | nty of Death | 7,20 | |
| -11 | Examine | " | Fallston | Genera | l Hospital | | | | | Falls | ton | | Har | ford | | |
| - | Funeral | | 5. Social Security Nu | | . Sex 7. A | ge (In yrs. last | birthday) | If Under | | | | 8. Dete of Birth | | 9. Birth | place (State o | x Foreign |
| L | Director | | 127-07-37 Usual Residence of I | | 110 M 2□ F | M 2 F 82 Yrs. Months Deys Hours Min. | | | | | 8. Dete of Birth (Month, Dey, NOV • 12, 1 | 12,1917 New York | | | | |
| | E 8 11 | 1 | | 10b. County | | 10c. City, T | own or Loc | cation | | | | | | 1 | IOd. Inside Ci | ty Limits |
| | ra Man 28a-f sh oddfied | Director | Maryland | Harfor | rd ———————— | Bel A | Air | 1404 75- | 0.4 | | | | | | 1 Yes | 2 No |
| | or death with the Maryland thems 23s or 28s-f show the must be notified at | ral Dir | 294 Cante | | | | | | 014 | | | | USA | | | |
| _ | ar, or its | by Fune | 11. Marital Status 1 Never Merrie 3 Widowed 4 | 12. Wes Decedent Armed Forces 1 | ? [No | It | Yes Dece Yes, spe | cify Cut | oan, Mexicar | n, Puerto | pecify Yes or No- Pican, etc.) | B | ece - Americ lack, White, hit? White | etc. | | |
| 5 | 72 h | Completed | | 15. Decedent's | Education grade completed) | 1 | 6a. Deced | kind of wo | rk done | during mos | t of worl | kina | 16b. Kind of | Business/In | dustry | |
| 21 | willtin Bran Ta Ma | ğ | Elementary/Secon | | College (1-4or | 5+) | life. D | O NOT u | se retire | ed) | i or won | 9 | | | | |
| e, Maryland 2 | Hed w Hygier Bher B | S | | | 2 | | Owne | r & (| Oper | rator | | | | | acturi | ng Co |
| | | 99 | 17. Father's Name (F | First, Middle, La | st) | | | | | | | e (First, Middle, N | | , | | |
| | | 0 | Joseph | Jacob | Braun | | | | | Anna | | М. | | Leyde | 1 | |
| | and 2 should saith and Mer m 27 is marks her traumatic | | 19e. Informant's Neme/Reletionship (Type, Print) Jane K. Braun-Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Top 294 Canterbury Road 294C, Bel Air | | | | | | | | | | | | 1014 | |
| | Pages 1 stent of He int: If Nem iny or other | | 1 Burial 2 □ | a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Secretary, cremetory or other place) | | | | | | | | | | | | nd |
| 量 | The state of the s | - | 4 □ Donation 5 21. Signatum t(Fun | | | Pat. | | | | ess of Facili | | 51/25 200 | O DCI | 1111/- | | 1100 |
| Ba | Dog In | | · | 9 01 | 7/ | | 7.6 | 0 | | 7 | TTou | ne, P.A. | | | | |
| | | _ | 1 808 | 1 411 | molications that cause by one cause on each I | | 13 | 17 C | oke | sbury | Road | l, Abingo | lon, M | aryla | nd 210 | 09 |
| | Physician /Medical Examiner | | Immediate Cause (F disease or condition resulting in death) | Finel | | | e/ | Syoc. | | | | furction | | 1 | Intervel Beth Onset end t | |
| 011 | P # 5 | | | | b | | | | | | | | | - 1 | | |
| 68760,0 | cate be executed physician and s the burlal-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | | | |
| Box 687 | nding physus as the | NMedical | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | | |
| | death ce | ruysiciany | Part II. Other signific | ent conditions | contributing to death t | but not resultin | a in the un | derlying o | ausa di | van in Part I | | 23b. Dld to | bacco use c | contribute t | o the cause o | of death? |
| P.0 | by the | | | | | | _ | | | | | 1 104 | | | bably 4 | |
| | igned be detected by Do | Dy | Chron | 10 06 | structive | 2 /0/ | 0000 | 204 | 01 | seas | € . | 1 007 11 | 2010 | , 00,,, | , v | O I I I I I I I I I I I I I I I I I I I |
| Vital Records, | aw requires to been a 2 should | pieted p | Pneu | monin | - * | | | | | | | 24e. Wes en | | av cc | ere autopsy t railable prior to empletion of c death? | 10 |
| œ | | E | | | | | | | | | | 1 □ Ye | s 200 No | 11 | □Yes 2□ | No |
| Ita | certificate rector, par | D | 25. Was case referre | ed to medical | | | | | | 26. Place | of Dee | th (Check only on | e) | | | |
| > | 2 00 2 | 0 | examiner? 1 ☐ Yes 2 ☐ 1 | 0 | Hospitel: 1 1 Inpati | ient 2 ER/ | /Outpatient | 3 DC | DA OI | ther: 4 Nu | ursing He | ome 5 Reside | nce 6 🗆 C | ther (Speci | fy) | |
| 100 | g Ph | | 27. Manner of Death | 5 C Boodine | 28a. Dete of Inju | ury 28 | b. Time of Injury | 2 | 28c. Inju | iry et | | 28d. Describe ho | w injury occ | urred | | |
| 0 | Attending in death. | | 1 ☐Natural 2 ☐ Accident | 5 Pending investigation | | , , , , | Hydry | М | | Yes 2 | No | | | | | |
| Division | hal or Attending Pt is after death. al Director: After the led in by the funera | | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not determine | 28e. Plece of In building, e | jury - At home | , tarm, stre | et, fector | y, office | | | 281. Location (St. City or Town | | mber or Run | al Route Num | ber, |
| | PERSON CONTRACTOR | | | | | | | | | | | | | | | |
| | To the Mospital or A within 24 hours after To the Funeral Direction Completely filled in Detail Carel | COLCOR | 29a. Certifier 1 (Check only 2 one) | © Certifying F ≥ Medical Ex | Physician: To the best aminer: On the basis of end menner st | of examinetion | dge, death and/or inv | occurred estigation | et the t | ime, dete en opinion, des | d plece, ith occur | end due to the ca red at the time, de | use(s) and i | manner as a e, and due t | stated. o the cause(s | •) |
| | Mithin to the comp | | 29b. Signature and ti | itle of certifier | 5 / | | | 290 | | se number | | 25 | 9d. Dete sign | ned (Month, | Day, Year) | |
| | | | • | 11.10 | wilon | | | | D | 3501 | 12 | 13 | Tanua | ry Z | 5,20 | 00 |
| | 6 | - | 20 Name and address of person who completed cause of death (Nam 22s) (Type Print) | | | | | | | Bel Air, Md. 21014 | | | | | | |
| | State | 2 | 31. Date filed (Month | , Day, Year) | 32. Regist | rar's Signeture | | | 1 | 700 | | DE 11/11 | 1 1.00 | - 210 | , , | |
| | Registrar | 7 | | JAN 31 | 2000 | 7 | 10. | 10 | par | K | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death January 24, 2000 7:60 P.M Ellen Bolich

7. Age (In vrs. last birthday)

77

4b. City, Town, or Location of Death

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 30, 1922 | Pennsylvania

Havre de Grace

4c. County of Death

Harford

9. Birthpiace (State or Foreign

Examiner **Funeral**

Physician

/Medical

Anna

10a State

5. Social Security Number

193-14-4969

Usual Residence of Decedent

4a Facility Nama (If not institution, giva straat and number)

1 M 2 X F

119 Robin Hood Road

10b. County

Director with the Meryland 7 le marked other than "natural", or itema 23a or 28a-f ahow treumatic event, the Medical Examinar name to notified at death permit. Peges 1 and 2 should be filled within 72 hours after to Department of Health end Mentel thygiene. If item 27 te marked other than "natural", or item to the marked other than "natural" or item to the marked other than "natural", or item to the marked other than "natural" or item to the marked other than "natural", or item to the marked other than "natural" or item to the marked other than "natur

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

other

6

any Injury o

shysician and the burief-transit P.O. Box 68760, physician ed by the a ate has been signed by page 2 should be detac Records, this certificate has Division of Vital funeral

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica To the Hospital of within 24 hours a To the Funeral D

10d. Inside City Limits 10c. City, Town or Location 1 Yas 3(T)No Director Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citlzen of What Country? 119 Robin Hood Road 21078 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - Amarican Indian, 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Secretary Civil Service 12 Ó 18. Mother's Nama (First, Middle, Meidan Sumama) 17. Father's Name (First, Middle, Last) Be William Drumbor Alletta UNK 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) Marianne J. Mancinho (Daughter) 1347 Macton Road, Street, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris &Co., Inc. 1/29/00 West Chester, PA 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the diseasa, or complications that caus shock, or heart failure. List only one cause on with the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, Approximata Intarval Between Onset and Daath Immediata Causa (Final SUDDEN disease or condition resulting in death) Examiner LARDIONASCULAR YEARS RIUSCLERCTIC Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequance of): ISEASE Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopay findings available prior to completion of causa of death? Completed 24a. Was an autopsy 1 ☐ Yes 1 ∏ Yas 2 ∏ No Be 25. Was cese referred to medicel 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Othar (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation Matural 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

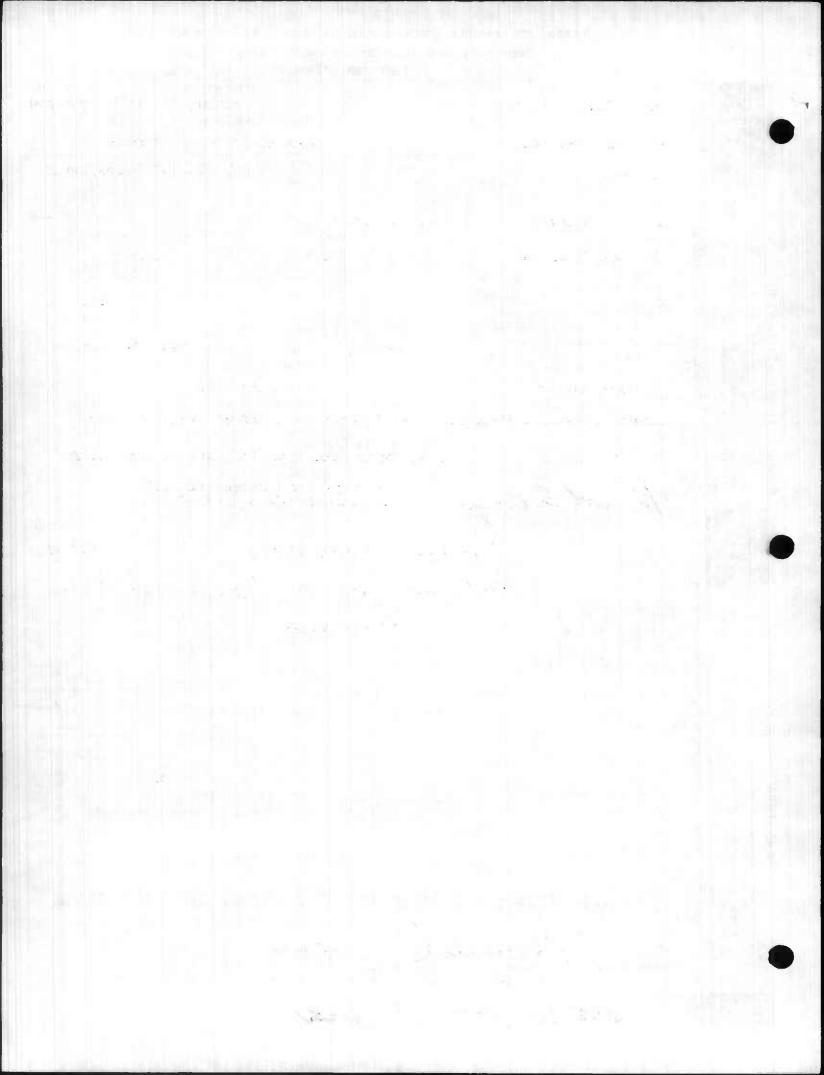
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. 29a. Certifier Medical 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and/little of cartities reausa of death (Item 23a) (Type, Print) 30. Name and address of person wi ALTIMORE, MD 21201 32. Figistrar's Signature 31. Date filed (Month, Dev. Year) **JAN 27**

DHMH 16 Rev 6/95

State

2000

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** BALL JANET 23, 2000 4:30 AM January /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Hours Days Months October 21,1932 South Caroling 1□ M 2□F 579-46-8601 67 Yrs. Director Usual Rasidence of Decedent 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits Show must be notified at 1 Ves 2 □ No Prince Georges Capitol Heights Directo Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7406 Shady Glen 20743 U.S.A. Funeral Terrace Nems 2 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Stetus Bleck, White, etc. 1 Yas 2 No 1 Never Marriad 2 Married ò 1 Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: natural. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Housekeeping 12th D.C. Government other vent of Health and Mental H; It: If Itam 27 is merked other V or other fee 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be John Brown Matilda Nelson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Hannibal Ball - Husband 7406 Shady Glen Terr. Capitol Hgts., MD 20743 20b. Plece of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Pauriel 2 Cramation 3 Ramoval from Stata permit. Pege Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln 1-29-00 Brentwood, Maryland 22. Name and Address of Facility
MArshall's Funeral Home, Inc. 21. Signature of Funeral Service Licenses 23a. Fakt. Entar the disaesa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, abock, or heart feilure. List only one ceuse on each line. 4217 9th Street n.W. Washington DC Approximete Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition rasulting in death) Examiner Examiner and Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in death) Last Dua to (or as a con price hrombo cuto Physician/Medical the Dua to (or as a consequence of): 980 ò signed by the a Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed has 2 PNo 1 ☐ Yes 2 ☐ No certificate funeral director. Be 25. Wes case rafarred to medical examinar? 26. Place of Deeth (Check only one) Hospital: 1 A Inpatient Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural s effer dea. 1 Yes 2 No 2 Accidant To the Hospital or Attar within 24 hours efter der To the Funeral Director completely filled in by th 6 Could not be detarmined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifian edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner stated. (Check only one)

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, Attanding Physician:

deeth with the Maryland

Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

21215-0020

Baltimore, Maryland

State Registrar

Σ

31. Data tiled (Month, Day, Year)

JAN 3 1 2000

29b. Signatura and little of certifia

SAMMIAN 32. Registrer's Signatura

un e and address of person who complated causa of death (Item 23a) (Type, Print)

MID

29c. License number

29d. Date signed (Month, Day, Year)

ALLEN TO THE STATE OF THE STATE

| Amend # 21 | .Per FH PGC 1-31-200 | State of Maryland | | nent of F | | | giene Reg. No. | JU | 15036 | |
|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------|------------------------------------|------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------|--|
| Physician /Medical | Decedent's Name (First, Middle, Last) RUTH As Facility Nama (Il not institution, give stress.) | INEZ | _ | BRAXT | ON 4b. City, Town, or L | | 1, 200 | Year | 3:00 P.M. | |
| Examiner Funeral Director | MILLIEUNNIUM OF LII 5. Social Security Number 6. Sex | | | | BALTIMORE | | th ny, Year) | 9. Birtho | | |
| 2 | Usual Residence of Decedant 10a. State 10b. County | 10c. City, | Town or Location | n | | | , | | Od. Inside City Limits | |
| 6 5 B | | | | | | | | | 1 No 2 No | |
| ler des leer des leer m | | 2. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva X Year or Dates: | | | lispanic Origin? (Span, Mexican, Puerto | pecify Yes or No Plican, etc.) | 14. | Race - Americ Black, Whita, | | |
| within 72 ho ens. then 'natur he Medical. | 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC ENGINEER HOME | | | | | | | | nd of Business/Industry | |
| at year of a should be filed not Mental Hygi marked other umatic event, I | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname SARAH TAYLOR | | | | | | | | | |
| C T IN L | 19a. Informent's Name/Relationship (Type WANDA BRAXTON WOOT! 20a. Mathod of Disposition 1 № Burial 2 □ Cremation 3 □ Rar 4 □ Donation 5 □ Othar (Specify) | EN, NIECE 20b. Pla noval from Stata | 8528 LU ce of Disposition matery, cremator LAH BAPT | CERNE (Name of y or other pla | ROAD BAL | Date | MD 21 | 133 on - City or To | | |
| Destinore, pemil. Pages 1 a Department of Hea Important; if ten any injury or othe anse | 21. Signature of Funaral Sarvice Licensee | O. WAL | | ERAL HOME | | | | | | |
| Physician /Medical Examiner | 23a. Part1. Enter the disaasa or complice shock, or haart failura. List only one Immediate Causa (Final diseasa or condition rasulting in death) | pne Due to (or o | Omore of a consequence of company of | | ng, such as cardiac | or respiratory a | mest, | | Approximate Interval Between Onset and Death | |
| death certificate be executed earthcriticate be executed of for use as the bunal-transit clan/Medical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disaesa or injury that initiated avents rasulting in death) Last | Due to (or e | es a consequence | 2017 | | | | | | |
| d by the detache | Part II. Other significant conditions contri | buting to death but not result | ing in the underly | ring cause giv | ren in Part I. | 1100000 | Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | |
| The law requires the cate has been signed, page 2 should be d | | | | | | perfo | an autopsy ormed? | av. co of | ere autopsy findings allable prior to mpletion of cause death? | |
| hysician his certifi il director | 25. Was case rafarred to medical axaminar? 1 Yas 2 No 27. Manner of Death 1 12 Netural 5 Pending 2 Accident invastigation | | R/Outpatient 3l 28b. Tima of Injury | 28c. Inju | | th (Check only one 5 Resi | one) dence 6 🗆 | Other (Specif |] Yes 2087No | |
| tal or Attending P is after death. al Director: After t led in by the funer: Certification: | 3 Suicide 6 Could not be detarmined | building, atc. (Specify) | of Injury - At home, ferm, street, fectory, office 28f. Location (Street and Number or Rural Route Nu | | | | | | | |
| To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert | 29a. Cartifier (Check only one) 1 Certifying Physic 2 Medical Examine: 29b. Signatura and title of cartifier | ian: To the best of my knowl r: On the basis of axaminatio and manner stated. | edge, death occu in and/or investig | arred at the tir ation, in my o | pinion, death occur | end due to the red at the time, | date and pla | ce, and due to | the cause(s) | |
| F3F8 |) Jleo | ploted onuce of death the | 12a) /F 5 | D3 | 0494 | | 29d. Data signed (Month, Day, Year) | | | |
| State | 30. Nama and address of person who com KIRIT DESAI, M.D. 31. Data filed (North, Day, Year) AN 3 1 2000 | | WILKINS | | BALTIMOR | E, MD | 21229 | | | |

Piease Type or Print In Black indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BROOKS-JACKSON SHIRLEY MARIE January 2000 3:55 AM /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Montha Days Hours 1 □ M 2 🗓 F 55 Yrs. 217-44-4196 Dec. 11, Director 1944 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yas 2 No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be WITH 12433 Persimmon Road 20772 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) School Teacher Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tern of them 27 is marked oth lary or other traumatic even Be George Edward Brooks Marie Elizabeth Butler 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Ronald J. Jackson/Husband 12433 Persimmon Rd, Upper Marlboro, Maryland 20772 20b. Plece of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, State 02/02 etery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State permit. Page Department of Important: If any Injury or Clinton, Maryland Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee Parca Nance 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Endonetrial Carcinoma /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eventa resulting In death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medicai Due to (or as a consequence of): 98 for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Records. P.O. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? should page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Affer 5 Pending investigation 1 MNatural within 24 hours after death. To the Funeral Director: A 1 Yea 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) e di 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

(15)

State Registrar TAI - Vi'u Yeung, ho 8926 U

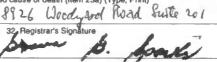
31. Date filed (Month, Day, Year)

FEB 0 1 2000

32. Registra

gui fugho

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Clinton 45

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FEB 0 1 2000

Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death AURA)ISHOP AM 2000 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WSS Silver Spring Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplace (State or Foreign Country) 1 M 2 F Months Deys 056-12-4803 Sept. 24, 1922 Washington, D. C. Usual Residence of Deceden 10a. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits towes 2□No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 17735 Norwood Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 XNo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status 1 □ Never Married 2 □ Merried 1 ☐ Yes 2 ☑ No Specify: Specify 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Statistical Manager Government 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Henderson I. Brooks Clara Washington 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 17735 Norwood Road, Sandy Spring, Maryland 20860 Wilma Bishop Dean - Daughter 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removet from Stete 4 Donetlon 5 Other (Specify) 2/4/2000 Suitland, MD Washington National Cemetery 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc. 21. Signature of Fuverel Service Licenses 4001 Benning Road, N.E., Washington, D.C. zn 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart teilure. List only one cause on each line. Approximete intervel Between Onset and Deeth Immediate Cause (Finet disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequença of) Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? BSTRUCTION 2º CARCINOMA 1 Yes 2 No GONEL 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of deeth? 24e. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medicat exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Maturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

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Examiner Completed by Physician/Medical Be Medical Certification: To

Physician

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Funeral

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Pages 1 and 2 should be file ment of Health end Mental Hy lant: If item 27 Ia marked oth

permit. Pages 1 and 2 s Department of Health or Important: If from 27 ta any injury or other trau

Physician /Medical

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21215-0020

Baitimore, Maryland

death. after death Director: completely filled in by 6 To the Hospital of within 24 hours at To the Funeral D

State Registrar

4 D Homicide

29e. Certifier (Check only one)

> ted cause of death (ttem 23e) Type, Print) 4701 Registrer's Signature

ORIGINAL

1 Certifying Physicien: fo the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated.

29c. License numbe

29d. Dete signed/(Month, Day, Year)

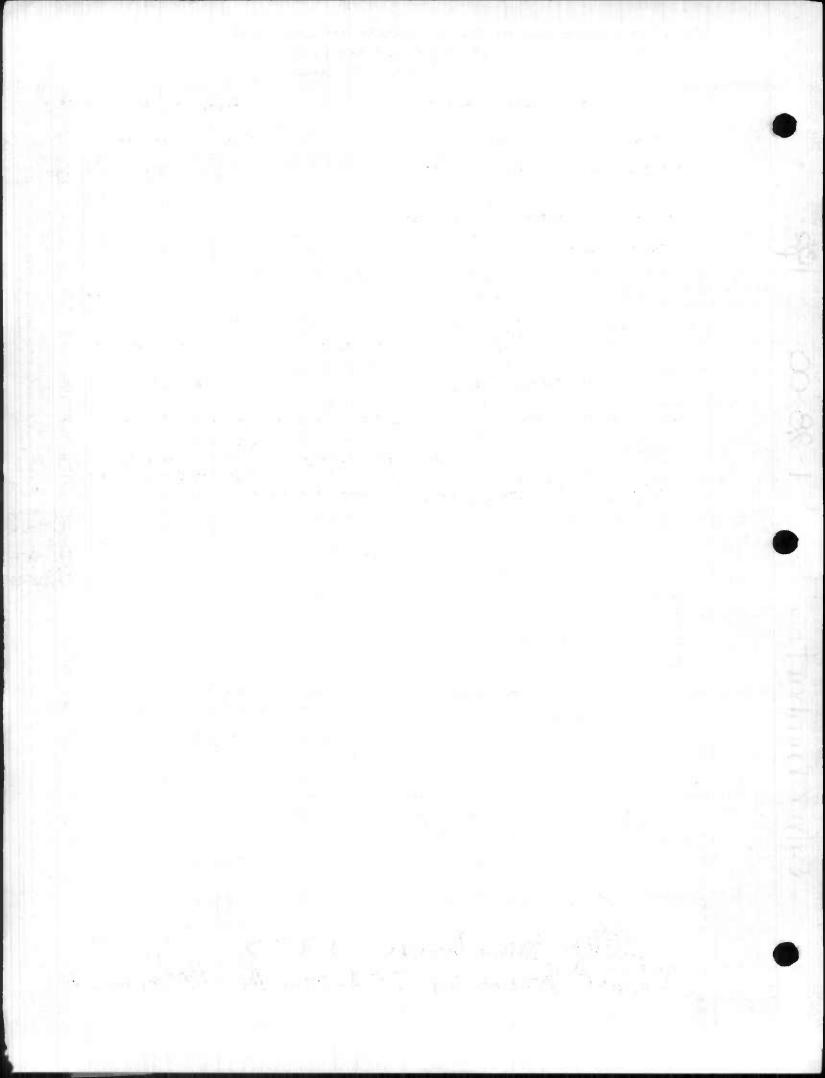
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| | | | State of Mar | ryland / [| Department of Certificate | of Health and of Death | | iene | 050 | 39 |
|----------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------|----------------------------------------|------------------------------------------------------------|-----------------------------|
| Physicia | an | 1. Decedent's Nama (First, Middle, Last) | | | | | 2. Date of Death | | r | a of Death |
| /Medic | al | Sylvia 4a. Facility Name (If not institution, give s | | NHART | | 4b. City, Town, or | January Location of Death | 28, 2000 4c. County of De | 1:3 | 35 p.m |
| | | Homewood Retireme | ent Home | | | Williams | sport | Washing | ton | |
| Funeral Director | | 5. Social Security Number 220-16-3680 6. Sax Usual Residence of Decedent | 7. Age M 2√2 F | (In yrs. last bir 84 | Months D | | | Year) 9.8 , 1915 We | irthplaca (Sta Country) St Vir | ta or Foreigr ginia |
| s or 28a-f show be notified at | tor | 10a. State 10b. County Maryland Washingt | | 10c. City, Town | | <u> </u> | | - | | City Limits |
| 25s or 28 ust be not | Funeral Director | 10e. Street and Number 11347 Greenberry F | Road | | 10f. Zip Co | 21740 | 10 | U.S.A. | Country? | |
| 0.8 | by | 11. Marital Status t Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: | | 13. Wes Decedant if Yas, specify 1 ☐ Yes 2 ☒ | of Hispanic Origin? (S Cuban, Mexican, Puer No Specify: | Specify Yes or No- to Rican, atc.) | 14. Raca - An Black, Wh Specify: | | |
| "natur edical | Completed | 15. Decedent's Educ (Specify only highast greds Elementary/Secondary (0-12) | cation completed) College (1-4or 5+) | | Decedent's Usual O (Give kind of work d life. DO NOT use n homemak | one during most of wo etired) | prking | her own | | |
| marked other than | To Be C | 17. Father's Name (First, Middle, Last) George Tho | mas McElo | ry | | | me (First, Middle, N Eliza Jan | | | |
| 4 4 | | 19e. tnforment's Name/Relationship (Tyr Mrs. Linda Young/ | | | | treet end Number or R Court, Wil | | | | 795 |
| | | 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R. 4 □ Donation 5 □ Other (Specify) | emoval trom State | cemeter | Disposition (Neme of y, cremetory or other Haven Ceme | r plece) | Feb. 1,2000 | 20c.Location - City of Hagerstow | n, Mar | |
| Important any injury snce | | 21. Signature of Poneral Service License | Ness | mil | 11 | ddress of Facility Wilson Bl | | Funeral lerstown, l | | nd 21 |
| /sician ledical aminer | _ | 23a. Part1. Enter the disease, or complishock, or heart teilure. List only on Immediate Cause (Final disease or condition rasulting in death) | | Hypu | Consequence of): | dylng, such es cardia | c or respiratory arre | sst, | | hate Between hd Death |
| been signed by the attending physician and should be detached for use as the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to Immediate cause. Enter Undertying Cause (Disease or Injury thet initiated events resulting in death) Last | | | consequence of): | ıs | | | 1/2 | /200 |
| attending for use as | Physician/Me | L d | | | | | | | | |
| ned by the s detached | by Physi | Pert II. Other significant conditions, con | tributing to death but | not resulting in | n the underlying caus | e given in Part I. | | bacco uss contribu | | Unknow |
| 2 should b | Completed b | R1647 H1 | An MA | HS. | | | 24a. Was ar perform | | o. Were sutop: available pri completion of death? | or to |
| s certificate has b | | 25. Was casa reterred to medical | | | | Of Place of De | 1 ☐ Ye | 71. | 1 ☐ Yes 2 | No No |
| this certificated rail director, | : To Be | examiner? | ospital: 1 Inpatlant 28a. Date of Injury | | | Other: 4 Nursing I | ath (Check only one Homa 5 ☐ Raside 28d. Describe ho | nce 8 □Other (Sp | pecify) | |
| To the Funeral Director: After thi completely filled in by the funeral | Certification: | 1 Shatural 5 Pending 2 Accident Invastigation 3 Suicide 6 Could not be | (Month, Dey) | (ear) II | military M | Injury at Work? 1 Yes 2 No | 281. Location (Str | reet end Number or i | Rural Routa N | lumber. |
| y filled in t | - | 29a. Certifier 1 artifying Physi | building, etc. | (Specify) my knowledge | , deeth occurred at the | ne time, date and place | City or Town | , Stete) | as steted. | |
| To the Funeral Director: After this certifical completely filled in by the funeral director, | Medical | (Check only 2 Medical Examinons) 29b. Signature in the object the | er: On the basis of er and menner stete | kamination and | d/or investigetion, in r | my opinion, death occurrence number | urred at the time, da | te and place, and de | ue to the caus | |
| | | 30. Name and address of person whyspor | MADICAL mpleted cause of dea | DINEC th (Itam, 23a) | Type, Print) |) 1706 | 7 | , 1/28/ | 12000 | 11 |
| Stat | te | 31. Data tiled (Monith, Dey, Year) FEB. 0 3 200 | TWEN, 32. Registrar | Uny | 747 No. | nthean 1 | the of | AGENITA | wyth | 4 |

Baltimore, Maryland 21215-0020



Piease Type or Print in Black indelibie Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January Ashley Wallace Buck 31, 2000 2:20 pm /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Millersville Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 15 M 20 F Months Deys Hours 94 080-03-4056 Director May 22, 1905 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Millersville Anne Arundel 1 Yes 2 No Director 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 21108 899 Cecil Avenue Completed by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Stetus filed within 72 hours after 1 Never Married 2 Married 21215-0020 White "natural", or 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced should be me-and Mental Hygiene. a marked other than "natural" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Mechanical Engineer Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file iment of Health and Mental Hi ant: If item 27 is marked oth lary or other treumatic even Be Chester Buck May Broughton 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Converse 5 Cedar Point, Severna Park, MD /daughter 20b. Place of Disposition (Name of cametery, crematory or other place) Feb Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any injury or Baltimore, MD Metro Crematory 2000 22 Name and Address of Facility Barranco & Sons, P.A.Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximete Interval Between failure. cause on each line Physician Immediate Cause (Final disease or condition resulting in death) /Medical week moumon's Due to (or as a consequence of): Exami Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): The law requires that the death Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 0.0 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 K Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) edical Certification: To 1 ☐ Yas 217 No this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15000 14 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CW #8 Glen Burnio, And 2,061 1916 Hung MO Crain 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

FEB 0 2 2000 January 1. 180. Ex

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13:07 Januar rnon 2.6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1₽₩ 2□ F Director 219-40-4833 56 1943 MARYLAND Usual Residence of Decede the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow must be notified at 1™ Yes 2□ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Ę, Norre 23a 215 ADMIRAL DRIVE
12. Was Decedent Ever in U.S. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Hace - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates: "natural", or item adical Examiner. Bleck, White, etc. filed within 72 hours after Hygiene. (ther then "netural", or its 1 Never Married 2 Married Specity: BLACK Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER SELF EMPLOYED Pages 1 and 2 should be filed vinant of Health and Mental Hygid not: If lean 27 is marked other in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 DIXON BROOKS ELIZABETH TONGUE 19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If Item 27 is any injury or other tra obce. KATHERINE BROOKS (WIFE) 215 ADMIRAL DRIVE ANNAPOLIS, MD 21401

20b. Place of Disposition (Name of cametery, cremetory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) CHEWS CHURCH CEMETERY 2/3/2000 OWENSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) nemia Examiner Que to (or as a consequence of). Examiner The law requires that the death certificate be axecuted 010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Due to (or es a consequence of): Physician/Medical for use as signed by the all d be detached for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 3 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 20 No. 20 NO 1 Yes 1 Yas Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 20 No Hospitat: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Natural 1 Yes 2 No 24 hours after death. V2□ Accident 3 Suicide 6 Could not be within 24 hours after de To the Funeral Directo completaly filled in by th 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical \$ 29b. Signature and title of certify 29c. License number 29d. Date signed (Month) Day, Year)

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

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polis

me and address of person who completed cause of death (Item 23a) (Type, Print)

2000

Fran

32. Registrar's Signature

a process of freeze

11 6 2 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Thomas Beckley. Jan. 2000 0929 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys Months Hours 1₩ 2□ F 171-03-6472 84 Dec. 22, 1916 Pennsylvania Usual Residence of Decedeni 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland 1 4 1 Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1860 St. Margarets Road 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: \ 1 Never Married 2 Merried 1□ Yes 2√□ No Specify: Specify: 3 ₩ Widowed 4 Divorced WIII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Claims Officer Social Security Administration 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Thomas B. Beckley Helen Pongrac 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Helen B. Jackson / Daughter 1860 St. Margarets Road Annapolis, Md. 21401 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method ol Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Orchard Hills Cemetery 01-28-00 Shamokin Dam, Pennsylvania

Physician /Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is married oth any Injury or other traumatic avami

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "natural", or items 23s or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after Hyglana. Wher than "natural", or he

aitimore, Maryland 21215-0020

Directo

Funeral

P

Completed

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21. Signatura of Funeral S

Immediate Cause (Final diseasa or condition resulting in death)

Vetural

2 Accident 3 Suicide

4 ☐ Homicide

29b. Signature and Jiff

298 Medical

death with the Maryland

Examiner

that the death certificate be executed

The

certificata

Box 68760,

P.0.

Records,

Division of Vital

Examiner burial-transit physician the buria Physician/Medical 980 signed b þ Completed Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certificalety filled in by the funeral director, I 8 Certification: To

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 24e. Was an autopsy performed? 25. Was case referred to medical 26. Place of Deeth (Check only one) axaminer? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. Our only one cause on each line.

completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2/4/0

22. Name and Address of Facility John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, Md. 21401

| Certifier (Check only one) | Certifying Physici Medical Examiner | an: To the best of my knowledge, death occurre On the basis of examination and/or investigati | red et the time, dete and place, and ion, in my opinion, deeth occurred | dua to the cause(s) and manner as stated. at the time, dete end place, and due to the cause(s |
|----------------------------|----------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|

Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

cause of death (Item 23a) (Type, Print)

41816 Franklin 2000

29d. Dete signed (Month, Day, Year)

3 Probably

Approximate Intervel Between Onset end Deeth

4 Unknown

24b. Were autopsy tindings available prior to

harles w "he-1 MD AAMC 15 31. Date liled (Month, Day, Year)

110/15

State Registrar

JAN 27 2000

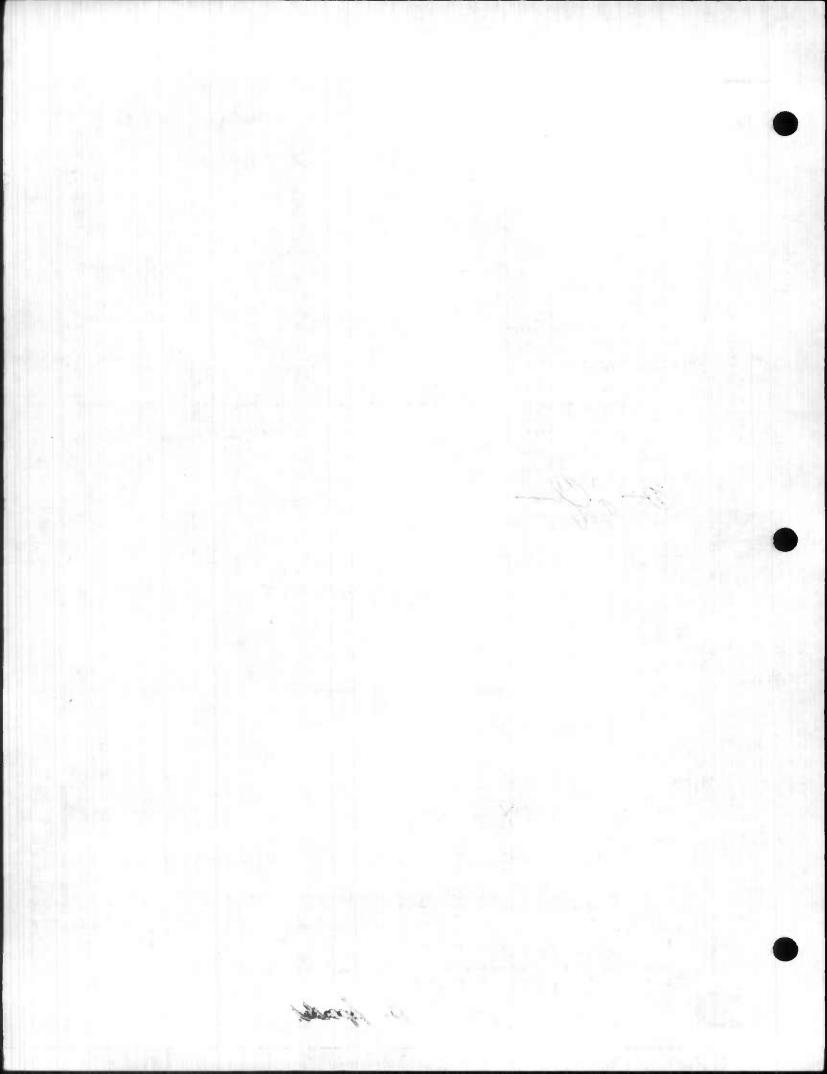
investigation

6 ☐ Could not be

32. Registrar's Signature

29c. License number

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dev Year JANUARY 29 2000 cation of Death 4c. County of Death Huling Paris Brown 1445 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Elkton 2745 Blue Ball Road If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Min. 10XM 20 F Months Days Hours 236-30-2685 74 May 31, 1925 West Virginia Usual Residence of Decedent 10a. State West 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Fayette Meadow Bridge Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 542 25976 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Merried 1 Yes 2 XNo Specify: Specify: White 3 Ø Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Miner Coal 8 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Carl Brown Eunice Corbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2745 Blue Ball Road, Elkton, Maryland 21921 Janet O'Dell/Daughter 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20s. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State FEB Spruce Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4,2000 Mt. Nebo, West Virginia 22. Name and Address of Fecility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses ald cho 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) conjustive heart 4 = RUS obstructive pulmenary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eneumo contesis 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yas 2DONo 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Daughter's Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Residence 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner physician and s the burial-transit Box 68760, P.O. Records, Division of Vital this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi funaral

Physician

/Medical

Examiner

Directo

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Completed

Funeral

Director

the Maryland

se filed within 72 hours after death with the Marylar of Hyllene.

I Hyllene in "natural", or herms 23s or 28s-f show yeart, Dre Marginal Eventheir man be inotified as yeart, bre Marginal Eventheir man be inotified as

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Ia marked other any Injury or other traumatic avent

Physician

Examiner

Physician/Medical

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Completed

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Certification:

Maryland

Baitimore,

1 Yes 2 No 27. Manner of Death 1 De Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

MD,

28c. Injury at Work? 1 TYes 2 TNo 28d. Describe how injury occurred

251 S. Bohemia Ave., Cecilton, and.

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(a) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of confine senshain m.D. 29c. License number

29d. Date signed (Month, Day, Year) D0035779 Junuary 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilnuce Obenshain,

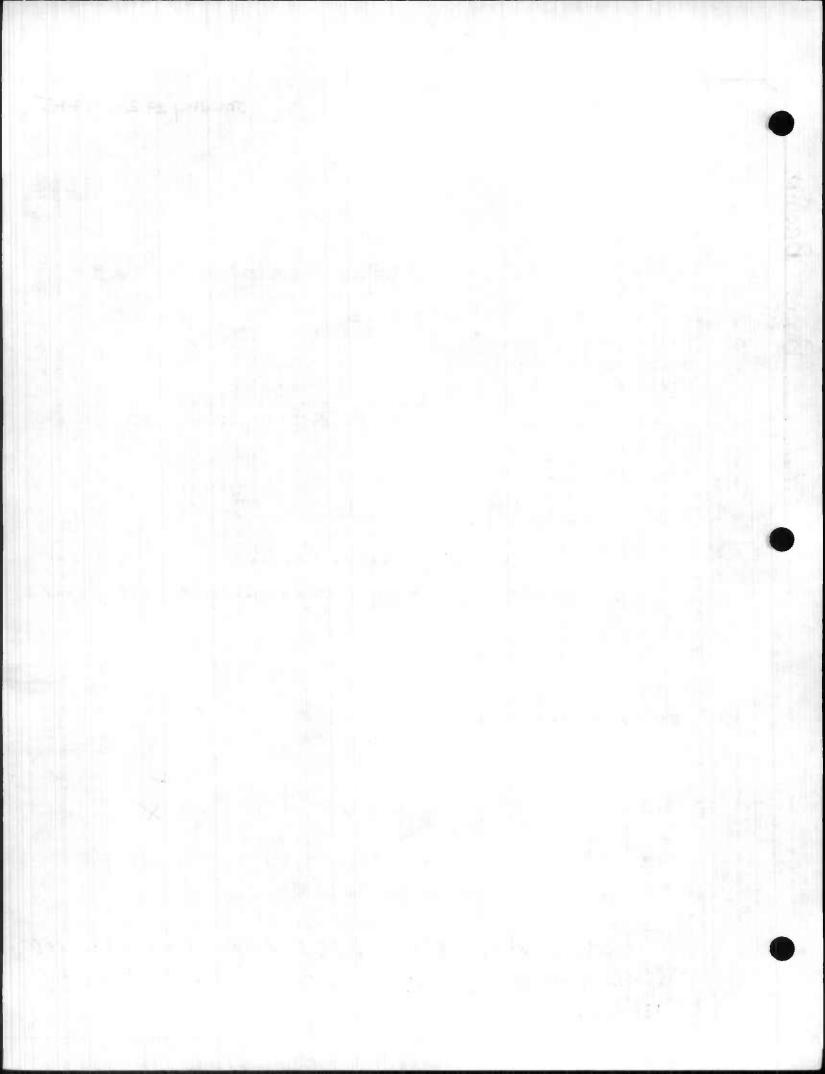
31. Date filed (Month, Day, Year) FEB 0 2 2000

32. Registrar's Signature

books

State

Registrar



Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** Helen M. Beilein February 3, 2000 7:50 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1351 Biggs Hwy. Rising Sun Cecil If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF Deys 77 Director 094-12-7643 Jan. 13, 1923 New York Usuef Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Cecil Risina Sun than "natural", or litems 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1351 Biggs Hwy. 21911 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yas, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Stetus Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If New 27 is marked or William Phillips Gladys Merrill 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Janice L. Persons/Daughter 1351 Biggs Hwy., Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 🛱 Removal from State 2-8-2000 Kenmore, New York 4 ☐ Donetion 5 ☐ Other (Specify) Elmlawn Cemetery 22. Nome and Address of Facility
R. T. Foard Funeral Home, P. A. 21. Signature of Funeral Service Licensee 23a. Part I Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

A. 21911

23a. Part I Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

A. 21911 Approximete Intervei Between Onset end Death **Physician** /Medical Immediate Cause (Finet ancel disease or condition resulting in death) Examiner Examiner sicien and bunal-transit Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): physicien s the burial Physician/Medical Due to (or as a consequence of) Pert ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Prior STroke by 24b. Wera sutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was casa referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner'of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturet 5 Pending 1 Yas 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pteca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai

Division of Vital Records.

P.O. Box 68760.

altimore, Maryland 21215-0020

State Registrar

29b. Signeture and title of certifier

Cobert a Martelone MI

3. Registrer's Signeture

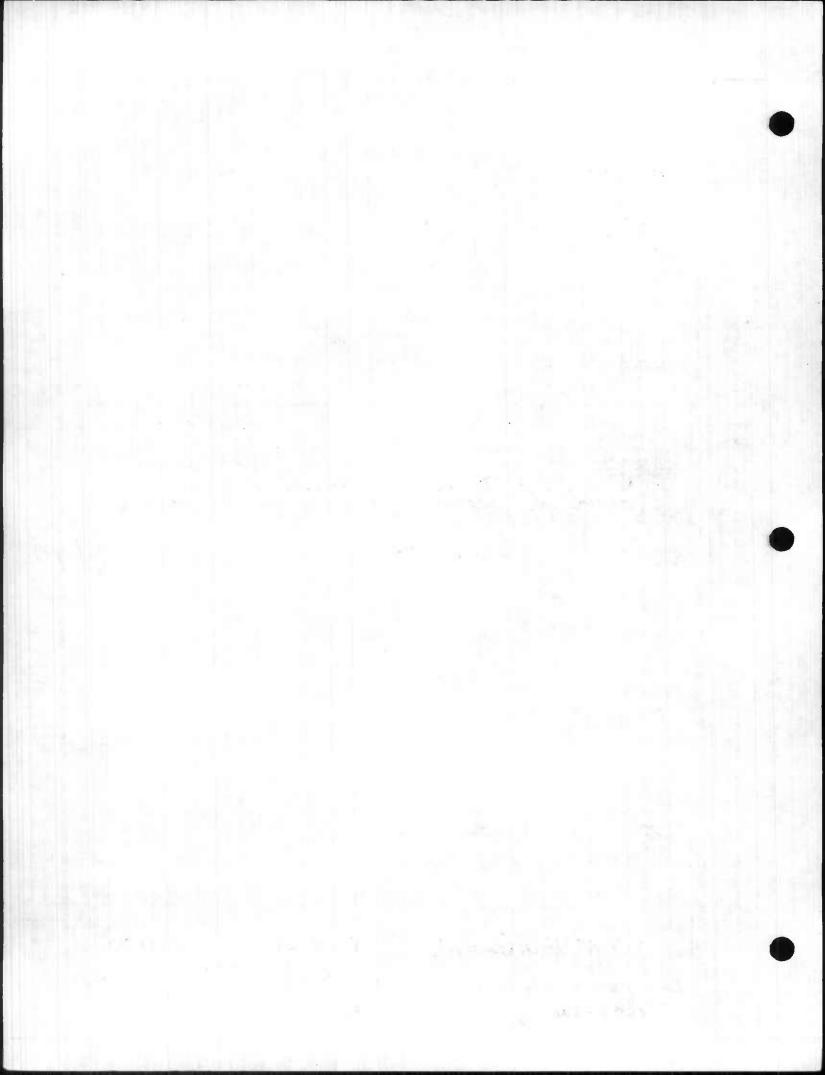
DHMH 16 Rsv 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Monteleone, MD Chesapeake Family Practice III W. High St. Ste 310 Elkton, MD 21921

29c. License number

00053675

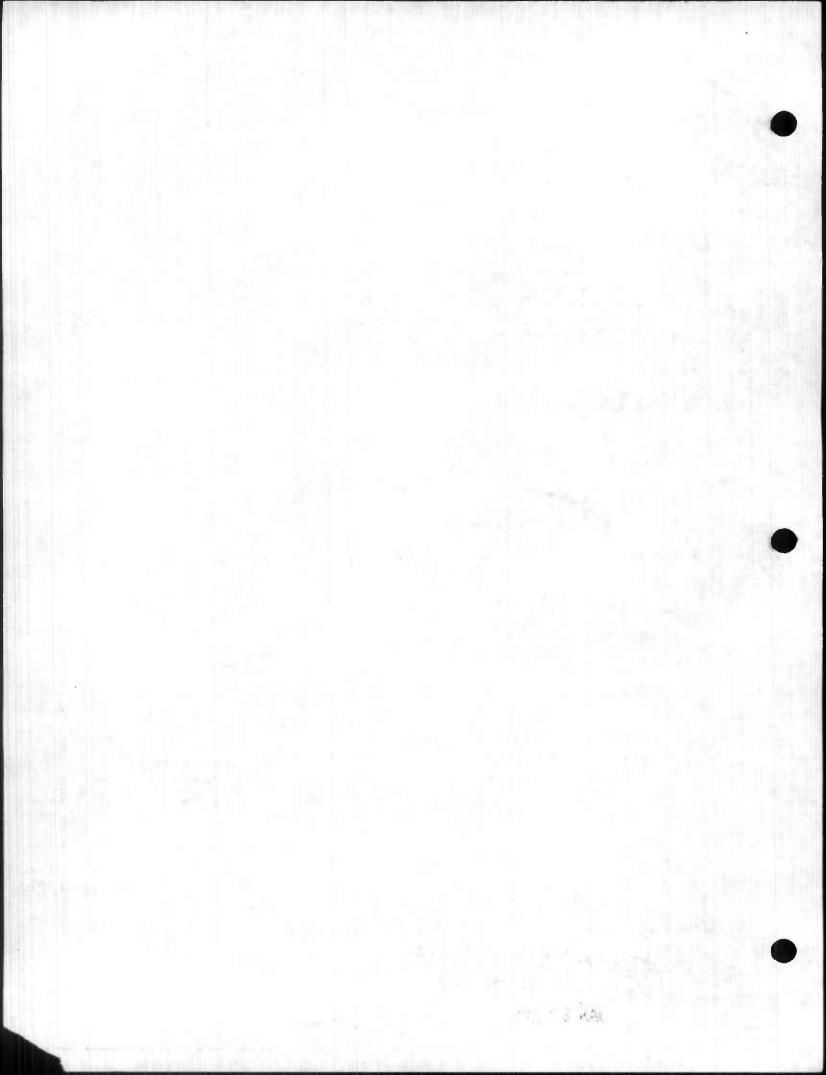
29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| Dep | artmo | ent | of | H | leal | th | and | Mental | Hygi | ene | - |
|-----|-------|-----|----|---|------|-----|-----|--------|------|-----|---|
| - | | | | | | - 4 | | | | | |

| | | | Cer | tificate of | Death | | Reg. No. | | |
|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------|---------------------------|----------------------------------|--------------------------------------------|------------------------|-------------|--------------------------------------|
| | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of De | ath | V | 3. Time of Death |
| Physician | Gerald Frank Batte | n | | | | Month Januar | y 24, 2 | Year 000 | 10:25 A.M. |
| /Medical Examiner | 4a Facility Name (If not institution, give stre | | | | 4b. City, Town, or | | 4 | | |
| LAdillilei | Carpenter's Point Ro | . & Mountai | n View | Road | Perryvil | lle. | C | ecil | |
| uneral | 5. Social Security Number 6. Sex | 7. Age (In yrs. | | If Under 1 Year | If Under 24 Hrs | 8. Date of Birt | h | 9. Birthp | place (State or Foreign |
| rirector | 186-22-4226 ^{1∑ M} Usual Residence of Decedent | ^{2□} F 70 | Yrs. | Months Deys | Hours Min. | May 16, | 1929 | | sylvania |
| 8 = | 10a. Stete 10b. County | 10c. Cit | y, Town or Loc | cation | | | | 1 | 10d. Inside City Limits |
| be nowled Director | Maryland Cecil | Per | rryvill | T | | | 10 077 | | 1 ☐ Yes 2 No |
| or Hems 23a or 28a-f show infinet must be notified at 7 Funeral Director | 10e. Street and Number 8 White Oak Drive | | | 10f. Zip Code 21903 | | | 10g. Citizen of United | | |
| r Hems 23u Miner must Funeral | | Was Decedent Ever in U | ,S. 13. V | Vas Decedent of | Hispanic Origin? (S | pecify Yes or No | | ce - Americ | |
| ar, or he by Fu | 1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | ☐ Yes 2 No | | o riioari, otc.) | Specif | | |
| | 15. Decedent's Educati (Specify only highest grade of | | 16a. Deced | ent's Usual Occu | pation during most of wo | rkina | 16b. Kind of B | - | |
| and a | Elementary/Secondery (0-12) | College (1-4or 5+) | life. D | O NOT use retin | ed) | | | | |
| 20 5 | 12 17. Father's Name (First, Middle, Last) | 4 | Combu | stion E | | me (First, Middle, | Steel I | | try |
| umatic ever | Frank Batton | | | | Thelma | Dhodos | | | |
| metic To | Frank Batten 19a. Informant's Neme/Relationship (Type, | Print) | 19h Mailia | n Address /Stree | I NE LMA | | er. City or Town | State Zin | Code) |
| a di | | rian) | | | | | | | |
| E S | Jere Batten / Son 20a. Method of Disposition | 30h F | | ladina P. sition (Name of | lace, Cel | ebration Date | 20c. Location | | |
| y or of | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | oval from State | cemetery, crem | natory or other pla | Ja | nuary | West C | heste | er, |
| Department of Health and Menta important: If than 27 is marked any injury or other traumatic an price. TO E | 21. Signature of Funerat Service-Licensee | K.A | | . Name end Addr | , Inc. | 27, 2000 | Pennsy | Lvan | ia |
| any is | 16480 | | | | neral Hom | | | ain St | treet, |
| - | 23a. Part1. Enter the duffine, or complicet shock, or heart falling. List only one of | ions thet caused the deet | h. Do not ente | or the mode of dy | t, Maryla ing, such as cerdie | c or respiretory e | rest, | | Approximate Intervel Between |
| sician | shock, of neert lending. List only one t | cause on eech line. | | | | | | | Onset end Deeth |
| ledical | Immediate Cause (Finel | TNT | PANRA | 1 SHO | TGUN W | AMILO | | ! | |
| aminer | disease or condition resulting in death) | | · · · · · · · · · · · · · · · · · · · | | 7 67070 60 | 001429 | | 1 | |
| ě | | Due to (c | or as a consequ | uence or). | | | | 1 | |
| ansit | Sequentially list conditions | Due to (c | or es a consequ | uence of): | | | | | |
| an and inter-transit Examiner | Sequentiatly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c | 238 10 (0 | | | | | | | |
| I physician and Is the bunal-transit edical Examir | that initiated events | Due to (c | or as a consequ | uence of): | | | | | |
| O d | resulting in death) Last | | | | | | | | |
| of for use | Does to Others classificant conditions contrib | with a second but and an | urfaire in the co | dadida anua - | iven in Bort I | 22b Did | lahesaa uee a | | to the cause of death? |
| ed by the attendir detached for use Physician/A | Part II. Other significant conditions contrib | outing to death but not res | ulling in the un | idenying ceuse g | wen in Part I. | | | | bably 4 🔀 Unknown |
| 58 5 | | | | | | | | T | |
| should should | | | | | | | an sutopsy | av | ere autopsy findings |
| has be ge 2 sh mple | | | | | | Lim | ited | of | ompletion of cause death? |
| page 2 should Completed | | | | | | 1)(0 | Yes 2□No | 10 | AYes 2 No |
| Be C | 25. Was case referred to medicel | | | | 26. Place of De | ath (Check only o | one) | 1 | |
| director, pag | examiner? TY Yes 2 No | pitat: 1 Inpatient 2 | ER/Outpatien | 3 DOA O | thor | lome 5□ Resi | | her (Specil | w at scene |
| eration T: T | 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | FOUND) 28c. Inju | ury at | 28d. Describe | how injury occu | irred | |
| S FE | | 1-24-00 (FOUND) | | | Yes 2 No | SUBJECT | SHOT | SELF | |
| To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (| 3 Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At h building, etc. (Specil WOODED AREA | - | eet, fectory, office | i . | 281. Location (City or Ton MOUNTAIN | vn, Stete) CAI | PLENTE | rel Route Number, CLS PT, RD, AND |
| within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification | 29a. Certifier 1 Certifying Physici | en: To the best of my kno : On the basis of examine | wiedge, deeth | occurred at the | time, dete end plece | e, and due to the | cause(s) end m | nenner as a | stated to the cause(s) |
| the Funer npletely fil fedical | ane) | and manner stated. | Anon strict or inte | | | seu at tire time, | | | |
| To the | 29b. Signeture end bitte of certifier | 1 1 | Y | 29c. Licer | nse number | | 29d. Date sign | ed (Month, | Day, Year) |
| | Hulan | rec. N | (-D | | O.C.M.E. | | January | 25, | 2000 |
| . 10 | 30. Name and address of person who comp | leted ceuse of deeth (Iter | n 23a) (Type, I | | | | | | |
| VD | Joseph 1 | Pestane | 1 | 11 Penn | Street, I | Baltimon | e. Marv | land | 21201 |
| State | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | | 1 1 | | | | | |
| Registrar | JAN 2 7 7 | WIII & Gene | var | 14 1 | 2-11 | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 5 0 4 6

| | State of Maryland | Certificate of Death | Reg. No. |
|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Physician | 1. Decedent's Neme (First, Middle, Last) | | 2. Dete of Death Month Dey Year 3. Time of Death |
| Physician /Medical | EMILY J. BUEG | | JAN. 27, 2000 11:35 PM |
| Examiner | 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Lo | |
| 0.54 | SHADY GROVE ADVENTIST HOS 5. Social Security Number 6. Sex 7. Age (In yrs. last) | | |
| Funeral Director | 079-14-6449 1□ M 2□€ 85 | Yrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) FEB • 21 , 1914 9. Birthplace (State or Foreign Country) NEW YORK |
| /land | 10s. State 10b. County 10c. City, To | own or Location | 10d. Inside City Limits |
| the Marylar 28s-f show notified at | MD. MONTGOMERY | ROCKVILLE | 1X Yes 2 No |
| Onfer death with the Manyland r flams 23s or 28e-f show finer must be notified a Funeral Director | 10e. Street and Number 9701 - VEIRS DRIVE | 10f. Zip Code 20850 | 10g. Citizen of What Country? USA |
| Rems Cuner | 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I | cify Yes or No- Rican, etc.) 14. Race - American Indian, Bleck, White, etc. |
| and 21215-0020 be filled within 72 hours eter a la hydiene. a other teen "natural", or tee avent, the Medical Farmine Be Completed by Ful | 1 Never Married 2 Merried 1 Yes 2 No | 1 ☐ Yes 2 ☑ No Specify: | Specify: WHITE |
| 72 hours natural; | 15. Decedent's Education (Specify only highest grade completed) | Ba. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) | 16b. Kind of Business/Industry |
| and 21215-0 be filed within 72 ho tal Mydiens. do other than "natural event, the leaders! Be Completed | Elementary/Secondary (0-12) College (1-4or 5+) | tite. DO NOT use retired) LIBRARIAN | LIBRARY |
| d 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 17. Fether's Name (First, Middle, Last) | | (First, Middle, Maiden Surname) |
| ylan Wental Mental Mental To B | LEWIS BUEG | EMIL: | IE BALLACH |
| THE SEE | 19a. Informant's Name/Relationship (Type, Print) KEN LERCH- NEPHEW | 9b. Mailing Address (Street and Number or Rura 7581 – FIREBIRD LA | Route Number, City or Town, State, Zip Code) , MANLIUS, NY 13104 |
| Officer officer | Came | of Disposition (Name of tery, crematory or other place) | Date 20c. Location - City or Town, State |
| Page Page Int: If | 1 Burial 2 MCremation 3 Removel from State 4 Donation 5 Other (Specify) | OPOLITAN CREMATORY | -1/29-ALEXANDRIA, VA. |
| Baltimore, M. pemit. Pages 1 and 2 Deperment of Heelih a Important: if then 27 in any Injury or other tre once. | 21. Signature of Funeral Service Licensee | 22. Name and Address of Fecility | |
| m goesa | W. M. Agona | HYSONG CO., INC. | WASH. DC |
| | 23a. Pert1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. | o not enter the mode of dying, such as cardiac o | r respiretory errest, Approximete Interval Between Onset and Deeth |
| Physician /Medical | Immediate Cause (Finet | | Crise(and Deelil |
| Examiner | disease or condition resulting in death) a. BOWEL | PREFORATION | HOURS |
| è è | | a consequence of): AL VASCULAR ACCIDE | NT YEARS |
| ecute Ind trans | D | a consequence of): | TBIRC |
| 68760, ifficate be executed gphysician and as the buriel-transit ledical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C. CONGES! | TIVE HEART FAILURE | |
| 687 licate | that initiated events resulting in death) Last Due Io (or as | e consequence of): | |
| | d | | |
| O. Be deeth the atte | Part II. Other significant conditions contributing to death but not resulting | in the underlying cause given in Pert I. | 23b. Did tobacco use contribute to the cause of death? |
| C + 700 H | | | 1 Yes 2 No 3 Probably Nunknown |
| ds, F | | | |
| Vital Records, idea: The law requires the conflicte has been signe rector, page 2 should be defector, be a Completed by | | | 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause |
| The law ste has page 2 | | | of death? |
| | 25. Was case referred to medical | 26. Place of Death | |
| of VIta nyeiclen: his centific I director. To Be (| examiner? | Othor | ne 5 Residence 8 Other (Specify) |
| | 27. Manner of Death 1 Death 28a. Date of Injury 28t. 1 Death 5 Pending (Month, Day Year) | | 28d. Describe how injury occurred |
| SIO seath. lor: Al the fu | 2 Accident investigation 3 Suicide 6 Could not be | M 1 Yes 2 No | |
| - +250 | 4 Homicide | ferm, street, fectory, office | 281. Location (Street and Number or Rural Route Number, City or Town, State) |
| Hosp 24 hou Fune tely fil | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowled to my knowled and manner stated. | ge, death occurred et the time, date and place, a and/or investigation, in my opinion, death occurre | and due to the cause(s) and manner as stated. Indicate the time, date and place, and dua to the cause(s) |
| To the within To the comple | 29b. Signature and title of certifier | 29c. License number | 29d Dete signed (Month, Day, Year) |
| \sim | Charles W. Karesh | W D21726 | January 28, 2000 |
| (2) | 30. Name and address of person who completed cause of death (Item 23s DR - CHARLES W - KARESH - 97 | n) (Type, Print) 01- VEIRS DR., ROC | KVILDE, MD. |
| State Registrar | 31. Date filed (Month, Day, Year) \$2. Registrar's Signature | 5, | ALM MAN |
| DHMH 16 Rev 6/95 | pagement 19. | Louis | |

ORIGINAL

Jan . Com

Please '

| | Ple | | ack Indelible Ink. Assure | | _ | |
|----------|-------------------------|-------------------|----------------------------|------------------------------|---------|------------------|
| | | State of Maryland | / Department of Health and | Mental Hygien | enn n! | 501.7 |
| | | | Certificate of Death | Reg. No | 000 | 0011 |
| 1. Deced | lent's Neme (First, Mic | die, Last) | | 2. Dete of Death Month De | ay Year | 3. Time of Deeth |
| ROY | WAYNE | BRANDON | | | 29 2000 | 10:24 A. |
| | | | | | | |

Physician /Medical Examiner

4a Facility Neme (If not institution, give street end number) Doctors Community Hospital 4b. City, Town, or Location of Death 4c. County of Death

A.M.

Funeral

5. Social Security Number 7. Age (In yrs. lest birthdey) 100 M 2 F 49 410-82-8144

Lanham If Under 1 Yeer If Under 24 Hrs. 8 Dete of Birth (Month Day) Days

Prince George's

Director

r than "natural", or hams 23s or 28s-4 show the Medical Executor must be notified at

filed within 72 hours after death

I Hygiene.

7 is marked other traumatic avent,

permit. Pages 1 and 2 should be fliel Department of Health and Mental Hy Important: If Nem 27 Is marked other eny Injury or other traumatic avent bace.

Physician

/Medical

Examiner

physician and s the burial-transit

980

ed by the a

d bengs

egad

Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

þ

Completed

Be

Medical Certification: To

The law requires that the death certificate be asscuted

Box 68760

P.O.

Division of Vital Records.

Baltimore, Maryland 21215-0020

Funeral

Completed by

10a. Stete 10e. Street and Number

10b. County Prince George's 10c. City, Town or Location College Park

Yrs.

9. Birthplece (State or Foreign Tennessee

10d. Inside City Limits

1 Yes 2 No

Maryland

8000 51st Avenue

Usual Residence of Decedent

12. Was Decedent Ever in U,S. Armed Forces?

20740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10g. Citizen of Whet Country? U.S.A.

11. Meritel Stetus

1 Never Married 2 Merried 3 ☐ Widowed 4 🗓 Divorced

1 ☐ Yes 2 📉 No If Yes, Give Year or Detes:

1 Yes 2 No Specify:

Auto Mechanic

10f. Zip Code

14. Rece - American Indian, Bleck, White, etc. Specify: Black.

Government

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

12th

17. Father's Neme (First, Middle, Last) Arthur Brandon

18. Mother's Neme (First, Middle, Malden Sumeme) Sarah Frances Manning

19e. Informent's Neme/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Burton Street, Jackson, Tennessee 38301

Hypertensive Cardio vo who Disease

Sarah F. Hines/Mother

20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Ptece of Disposition (Name of cemetery, cremetory or other place) Maryland National Memorial Pk.

20c. Location - City or Town, Stete 02/05

Laurel, Maryland

21. Signeture of Funerel Service Licenses

Nancus ma dise Perce 23a. Pen1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiretory arrest, shock, or heart failures. List only one cause on each line.

J.B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)

Due to (or es a consequenca of)

Due to (or es e consequença of)

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy parformed?

24b. Were autopsy findings evailable prior to completion of cause of death?

2 No

2 No

25. Was case referred to medical TXXYes 2□ No

Manner of Death 5 Pending 2 Accident investigetion

6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

29a. Certifler

3 ☐ Suicide

4 Homtcide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

**Common Physician: To the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner stated.

29c. License number

29b. Signeture and title of certifier

O.C.M.E. res

29d. Date signed (Month, Day, Year) January 30, 2000

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

THEODORE MIKE 31. Dete fited (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

26. Piece of Deeth (Check only one)

State Registrar

FEB 0 4 2000

32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

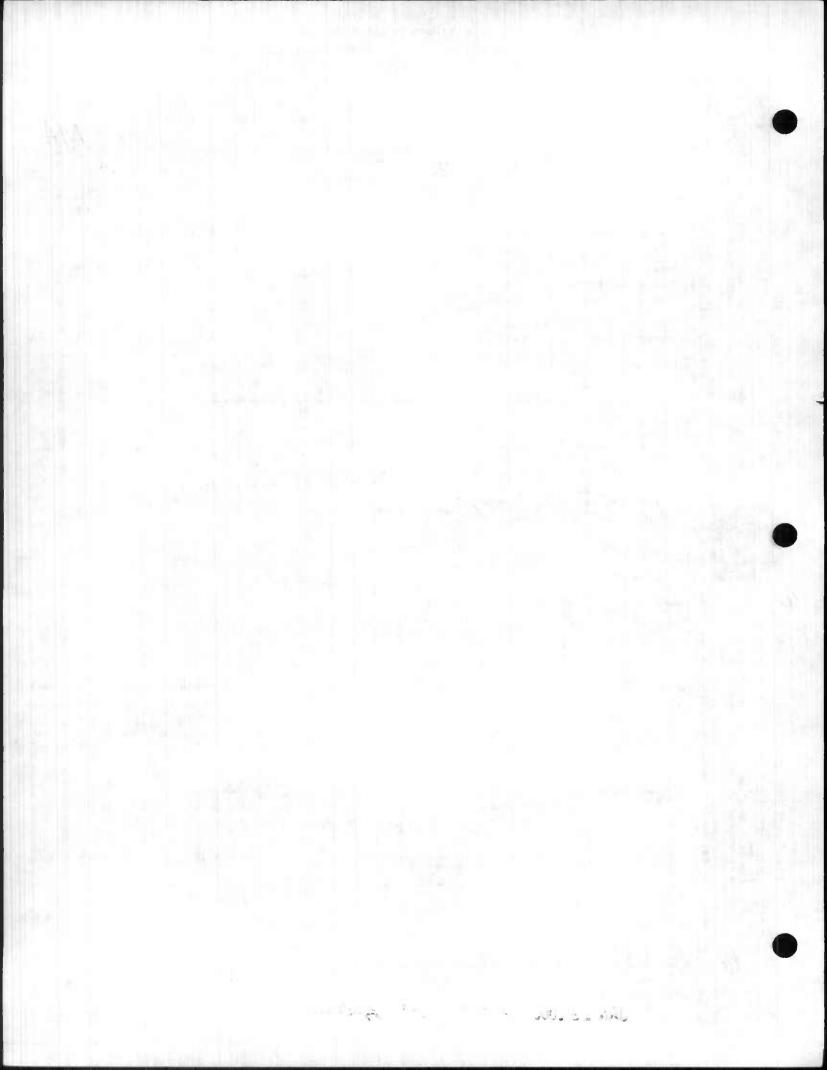
DHMH 16 Rev 6/95

FEB 9 - 2000 James 19. Aprelia

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | Certificate of | of Death | 100:10 | Reg. No. | | 00.0 |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------|-------------------------------------------------------------------|-------------------------------------------|---------------------------------------|-----------------------------|------------------------------------------------------------------------|
| Physician | Dorothy Buck 1. Decedent's Name (First, Middle, La. DOROTHY Buck | CHANAN | | | | 2. Date of De Month | Day | Year | 3. Time of Death 2:45 PM |
| /Medical | 4a Facility Name (If not institution, give | | | | 4h City Town o | Janua Location of Deat | 1 | OOO | 2.40 |
| Examiner | Johns Hopkins | Bayview Me | | | Baltim | ore | | or Death | NIA |
| Funeral Director | 5. Social Security Number 6. S 217–68–2965 Usual Residence of Decedent | ex 7. Age (Ir | yrs. last birtho | Months Da | | 8. Date of Bin (Month, Di Mar. 2 | th Year) 4, 1919 | 9. Birthpl Count Mary | ace (State or Foreign 12) Land |
| B m | 10a. State 10b. County | 10 | c. City, Town o | r Location | | | | 10 | Od. Inside City Limits |
| or 21s-f show be notified at Director | MD Harfo | ord | Abero | deen | | | | | ¥2 Yaa 2□No |
| or 28s-f s be notified Director | 10e. Street and Number | | | 10f. Zip Cod | 0 | | 10g. Citizen of W | hat Count | lry? |
| al D | 411 Washington | Street | | 210 | 01 | | U.S. | Α. | |
| ursi', or items at Examinar m od by Funer | 11, Marital Status 1 Never Married 2 Married 3 Never Married 2 Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2000 of Yes, Give Year or Dates: | r in U,S. | 13. Wes Decedent If Yes, specify C | of Hispanic Origin? (uban, Mexican, Pue No <i>Specify:</i> | Specify Yes or No orto Rican, etc.) | | - America c, White, e | etc. |
| disal | 15. Decedent's Ed (Specify only highest gra | fucation | 16a. D | ecedent's Usuel Oc | cupation | orkina | 16b. Kind of Bu | siness/Ind | ustry |
| yglera. Ner than "natur ft, the Medical. | Elementary/Secondary (0-12) | College (1-4or 5+) | - Si | | ne during most of w ired) | 10.00 | | | |
| | 6 | 0 | l | Homem | | (F) A2 | In hor | | 7 |
| B state | 17. Father's Name (First, Middle, Last) | | | | | ame (First, Middle | , Maiden Sumami | B <i>)</i> | |
| To men | UNK | | 1 | | | ie Hardy | | | |
| T la tr | 19a. Informant'a Name/Relationship (Gloria Weddle (| | | III. | eet and Number or I | | | | Code) |
| Final Over 2 | 20a. Method of Disposition | 19 | Ob Diago of D | ienocition (Alama o | ton St., | Date Date | MD 210 | | en State |
| timent of tank: If In dury or o | 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specific | Removal from State | Mt. Cal | crematory or other Lvary Ceme | etery | 1/21/00 | | | |
| Depa Impo any is ansa | 21. Signature of Europeal Service Licen | 3 Days | 2 | Aberdee | -Cargo Fu | nd 2100° | 1-3399 | | |
| hysician | 23a, Part1. Enter the disease, or com- shock, or heart failure. List only | | | | dying, such as cardi | ec or respiretory e | orrest, | | Approximete Intervei Between Onset and Death |
| /Medical xaminer | fmmediate Cause (Finel disease or condition resulting in death) | 8. | heumo | | | | | 1 | 2 months |
| è | | | | | ive Pulm | onary b | isease. | 2 | Lo years. |
| physician and as the buriel-transit edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due Due | to (or as e cor | nsequence of): | | | | | 5 days |
| physicia s the bur adical | Cause (Disease or injury that initiated events resulting in death) Last | G | PEUMOT to (or as a con | | | | | | |
| 0 8 | C | d | | | | | | 1 | |
| d for | Part If. Other significant conditions of | ontributing to death but no | ot resulting in th | ne underlying cause | given in Pert I. | 23b. Did | tobacco usa con | tributa to | the cause of death |
| signed by the ettendin to detached for use by Physician/M | Control of the second s | | • | | | | | | ably 4 Unknow |
| 2 should | | | | | | 24e. Wes | an autopsy ormed? | ava | re autopsy findings illable prior to npletion of cause leath? |
| Page h | | | | | | 10 | Yes 2 No | 1□ | Yes 2000 |
| certificate hursector, page | 25. Was case referred to medical examiner? | | | | | eath (Check only | one) | | |
| E E | 1 Yes 2 No | | 2 ☐ ER/Outpo | MINN 3L DUA | | Home 5□ Res | | 1.7 |) |
| 2 5 | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | | ar) 28b. Tirr Inju | | njury et Work? I ☐ Yes 2 ☐ No | 28d. Describe | how injury occurre | ed | |
| O O D | 3 Suicide 6 Could not be determined | 28e. Place of Injury - building, etc. (S | At home, ferm pecify) | , street, fectory, offi | СӨ | | Street and Number wn, State) | er or Rura | Route Number, |
| in 24 hou he Funer pietely fill edical | 29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Exam | ysician: To the best of my niner: On the basis of exa and manner stated. | y knowledge, d mination and/o | eath occurred at the rinvestigetion, in n | e time, date and piac by opinion, death oc | ce, and due to the curred et the time, | cause(s) and mai date end pleca, a | nner as st and due to | ated. the cause(s) |
| within 2 comple | 29b. Signature and title of certifier | 1 | | | ense number | | 29d. Date signed | (Month, I | Day, Year) |
| | Varan Ded | WA MD | | | 20303 | | Januar | y 16 | 2000 |
| 1 | 0000 | | | | | | | | |
| 1 | 30. Name and address of person who a | completed cause of death | | rpe, Print) Lnue Ba | Itimore, | Maryland | d 2122 | 4 . | |

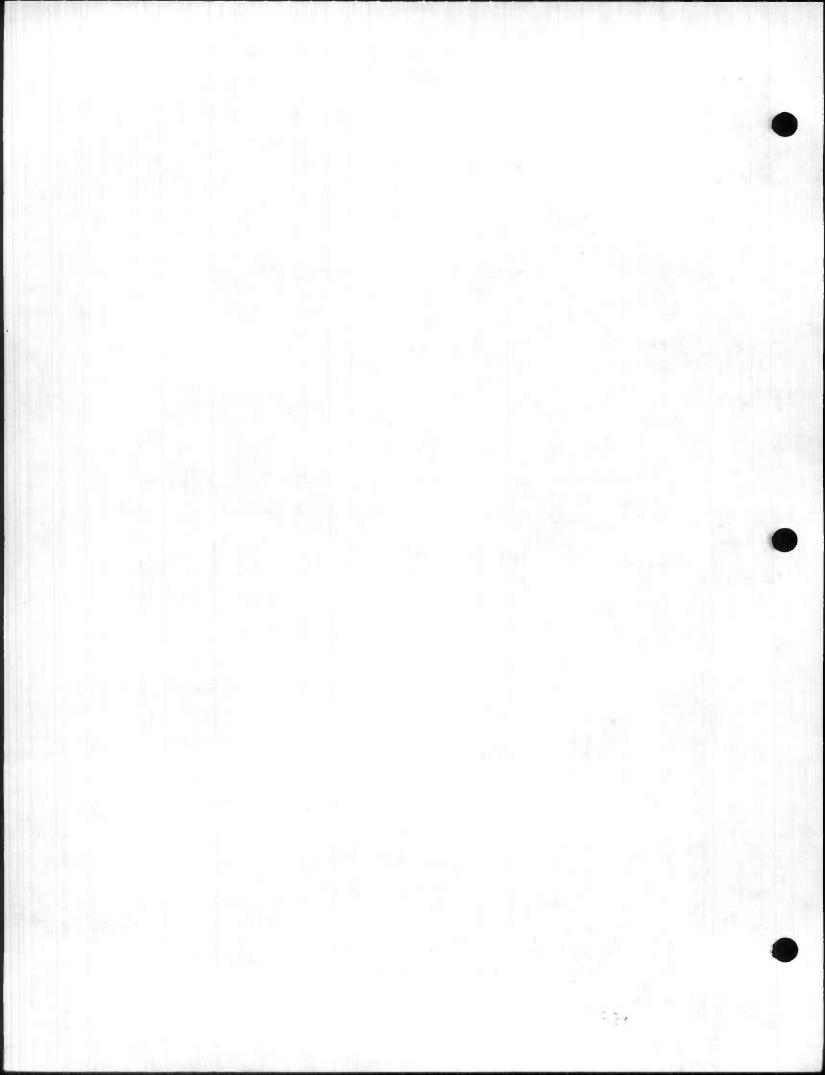


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State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 4 9

| | | | | Otato or ini | aryland | | ficate of | Death | | Reg. No. | U | 0042 |
|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------|-------------------------------------------|-------------------------------------|-----------------------------------------------|------------------------------------------|-----------------------------------|-------------------------|----------------------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, Le | rst) | | | | | 2. Date of Dea | | V | 3. Time of Death |
| | Physic /Medi | | MARY BEV | ERLY | | BUF | RKE | | JAN. | 30 200 | Year O | 2015 |
| | Exami | | 4a Facility Name (If not institution, gir | e street and number) | | | | 4b. City, Town, or Lo | ocation of Death | 4c. County | of Death | |
| | | | HOSPICE HOUSE | | | | | EASTON | V | | TALBO | T |
| | Funeral Birector | | 267-28-2829 | Sex 1□M 2XXF 7. Ag | e (in yrs. lasi 7 | | f Under 1 Year Months Days | | 8. Date of Birt (Month, Da APR. 20 | y, Year) | | olace (State or Foreig htry) AWARE |
| | E | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, T | Town or Locat | ion | | | | 1 | Od. Inside City Limit |
| | the Maryland 28e-f show notified at | ŏ | MD TALB | OTT | | MICHA | | | | | | XXYes 2□N |
| | 2 4 | Director | 10e. Street and Number | 01 | 51. | | 10f. Zip Code | | | 10g. Citizen of | What Cour | ntry? |
| | Will be or | 0 | 801 RIVERVIEW T | ERRACE | | | 2166 | 3 | | | JSA | , |
| 20 | within 72 hours after death with the Marylar ene. than "natural", or herre 23e or 28e-f show he Medical Examiner must be notified at | by Funeral | 11. Marital Status **Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Armed Forces? Y Ayes 2 1 | No | 10 | s Decedent of es, specify Cut | Hispenic Origin? (Spoen, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Rad Bla Specifi | ck, White, | ean Indian, etc. HITE |
| 21215-0020 | To a series | P | 15. Decedent's E | Year or Dates: | | | t's Usual Occu | nation | | 10h Kind of B | ualaasa/la | duetes |
| 15 | ST TE | Completed | (Specify only highest gr | ade completed) | | (Give kin | d of work done NOT use retire | during most of work | ing | 16b. Kind of B | usinesa/in | dustry |
| 212 | Page N | ф | Elementary/Secondery (0-12) | Cotlege (1-4or 5 | | | r speci | | | U.S. GO | OVERN | MENT |
| | BE THE | | 17. Father's Name (First, Middle, Last | | | DODGE | . OI DOI | 18. Mother's Neme | e (First, Middle, | Meiden Surnan | ne) | |
| la la | d be entail cent | To Be | WILLIAM JOSE | PH BURKE | | | | MARIE | RUS | SSELL | | |
| Maryland | DOM PR | F | 19a. Informant's Neme/Relationship | | | 19b. Meiling / | Address (Stree | t and Number or Run | | | State. Zir. | Code) |
| | and 2 is loath ar m 27 is her trau | | MARGARET B. FREE | | TER | P.O. | BOX 11 | 3, SHERWOO | DD, MD | 21665 | | |
| Baltimore, | Department of H Department of H Important: If No any Injury or of ance. | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci | | cem | e of Dispositi etery, cremat APEAKE | one or other ole | ION CTR. | 2-1-00 | CHESTE | | |
| Bal | Depart Import any in | | 21. Signature of Funerel Service Lice | nsee | | FELI | | ess of Facility ELFENBEIN RISON ST. | | | | OME, P.A. |
| | _ | | 23a. Part1. Enter the diseese, or com | plications that caused | the deeth. I | Do not enter t | he mode of dy | ing, such as cardiec | or respiratory ar | rest, | 1001 | Approximate |
| SV. | Physician | н | shock, or heart failure. List only | | | | | | | | - 1 | Interval Between Onset and Death |
| | /Medical | | tmmediate Cause (Finel | chro | nie c | hstin | ative. | pulmono | my dis | cerse | | YRAVS |
| | Examiner | ш | disease or condition resulting in deeth) | a | | s a conseque | | P | | | 1 | 1 |
| | | je | | | Due 10 (01 a. | a conseque | rica orj. | | | | | |
| | and and al-transi | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b | Due to (or as | s a conseque | nce of): | | | | 1 | |
| 68760, | ificate be executed g physician and as the bunal-transit | edical | Cause (Disease or injury that initiated events rasulting in death) Last | c | Due to (or as | a consequer | nca of): | | | | | |
| | | | | d | | | | | | | | |
| Box | atte atte | Cia | Dati Oh a la Mara | | | | | | no pid | | 4.10 4-4 | |
| o | the d | ys | Pert II. Other algnificant conditions of | ontributing to death b | ut not resultir | ng in the unde | mying cause g | iven in Pert I. | | | | o the cause of death |
| σ. | that ded b | P | Polymyelqua | Pheunat | cen | | | | and, | Yas 2 No | 3 Pro | bably 4 Unknow |
| Division of Vital Records, P.O. | ysician: The lew requires that the death cert is certificate has been signed by the attendin director, page 2 should be deteched for use | Completed by Physician/M | 0 0 | | | | | | 24a. Wes | en autopsy med? | av | ere autopsy lindings allable prior to empletion of cause |
| Rec | he lew te has b age 2 s | omple | | | | | | | 101 | ras 2.0 No | of | death? |
| ta | an: tifica tor. p | Bec | 25. Was case referred to medical | | | | | 26. Place of Deet | h (Check only o | ne) | | |
| > | Attending Physician: ar death. ector: After this certific by the funeral director, | ToE | examiner? 1 Yes 212 No | Hospitel: | nt 2 ER | /Outpetient | 3 DOA OI | her: 4 Nursing Ho | | | ner (Specia | WHOSPICE |
| 0 | £ 50 | | 27. Menner of Deeth | 28a. Date of tnju (Month, De | ry 28 | Bb. Time of Injury | 28c. Inju | | 28d. Describe I | | | V SQINS I |
| ō | ath. r: Aft | atlo | 1-®Neturat 5 ☐ Pending investigatio | | 7 7 00.7 | прату | | Yes 2 □ No | | | | |
| Divis | or Attende Directo | Certification: | 3 Suicide 6 Could not be determined | | ury - At home c. (Specify) | e, larm, street | , fectory, office | | 28I. Location (S City or Tox | | ber or Run | Il Route Number, |
| | To the Hospital or Attending Phywitin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | edical C | 29a. Certifier (Check only one) Certifying Property 2 Medicat Exerging Property (Check only one) | yalcian: To the best oniner: On the basis of and manner sta | examinetion | dge, death oc and/or inves | ccurred et the t tigation, in my | ime, dete end plece, opinion, deeth occurr | and due to the red at the time, | cause(s) end m dete end place, | anner as a and due t | stated. the cause(s) |
| | o the | Me | 29b. Signature and title of sertifier | 7 | | | 29c. Licen | se number | | 29d. Date signe | ed (Month, | Day, Year) |
| | F 3 F 8 | | 16 mm | llow v | ~~ | | D39 | 749 | | 1/31/ | 100 | |
| | | Ì | 30. Name and address of person who | completed cause of d | eath (Item 23 | 3a) (Type, Pri | nt) | | | | | 11 11 142 |
| | | | DAVID G. OLIVER | , M.D., 50 | 3 DUT | CHMAN' | S LANE, | EASTON, | MD 2160 | 1 | | |
| | Sta | | 31. Date filed (Month, Day, Year) | | er's Signeture | 14 | 1- | 1 | | | | |
| | Registr | ar | FEB 0 2 2 | JUO July | John Land | pul. | sport | 2/ | | | | |

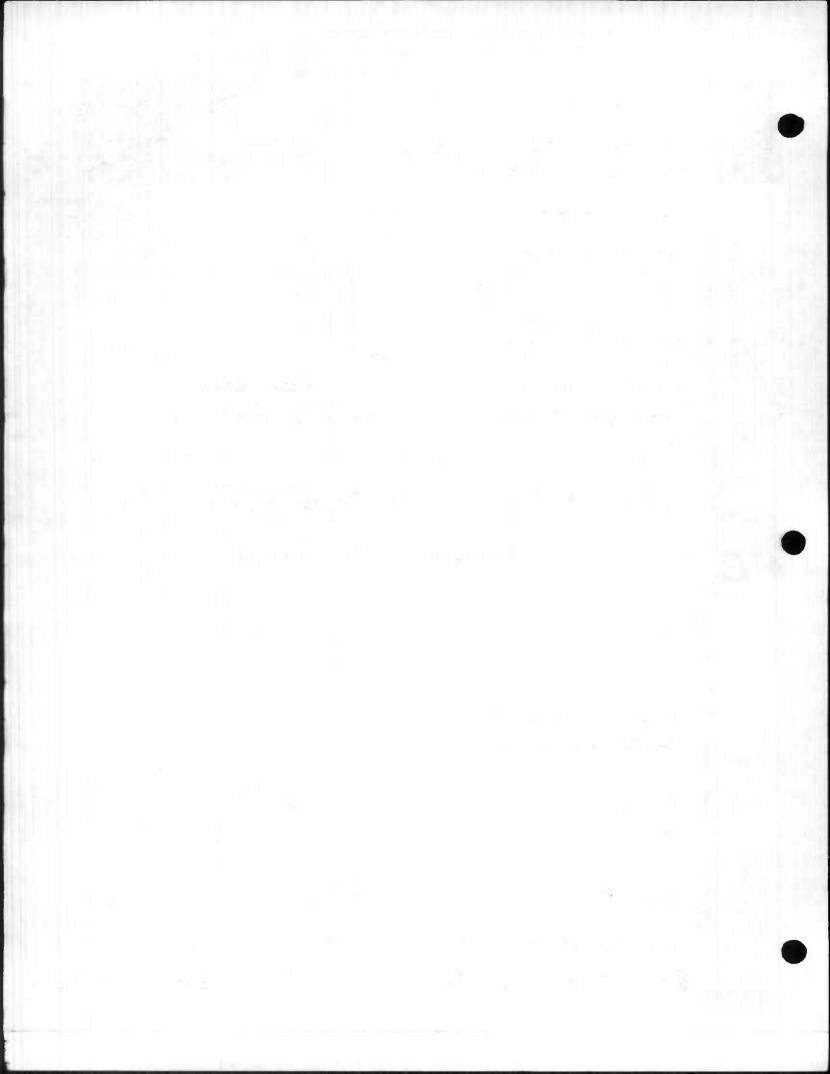
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State of Maryland / Department of Health and Mental Hygiene

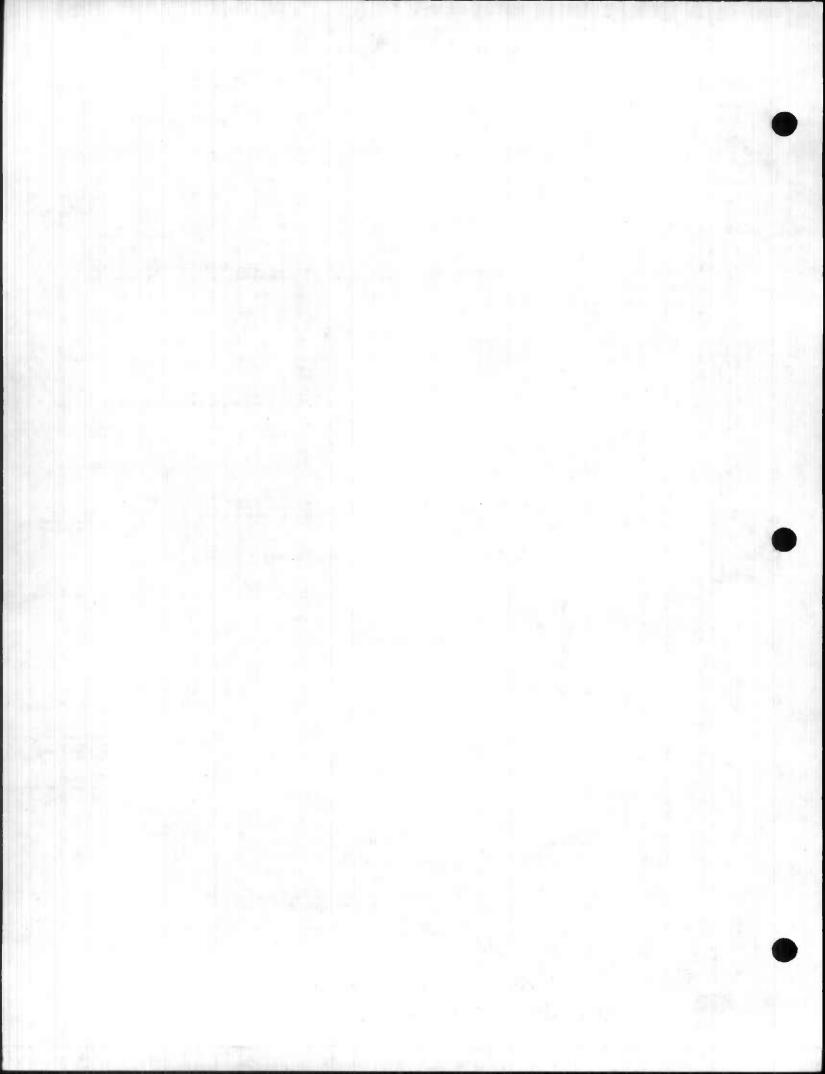
| | | | | | | Certific | cate of | Death | | | Reg. No. | | |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------|---------------|------------------|----------------------|-------------|---------------------------------|-----------------------|---------------|---------------------------------------------------------------|
| | | | 1. Decedent's Neme (First, Middle, La | st) | | | | | | 2. Data of De | ath | | 3. Time of Death |
| | Physic | | LOLA E. BELL | | | | | | | Jan | 31 2 | Year 2000 | 6:40 AM |
| V | /Medi Examir | | 4a. Facility Name (If not institution, giv | a street and number) | | | | 4b. City, To | own, or Lo | cation of Deeth | | ty of Death | 0:40 AM |
| и | LAGIIII | 101 | The second secon | | | | | Ea | stor | 1 | | albot | |
| Н | Funeral | | Genesis Elder | Care - Tr | ne Pine | thday) If U | Jndar 1 Yaar | If Under | | 8. Date of Birt | h | | |
| | Director | | 213-22-7991 | □ M 2KXF 96 | | Yrs. Moi | nths Days | Hours | Min. | JUNE 2 | y, Year) | MARYI | place (Stete or Foreign htry) |
| Ш. | | | Usual Residence of Dacedant | | | | | | ! | JUNE 2 | 1703 | PIAKTI | LAND |
| | how | | 10a. State 10b. County | | 10c. City, Town | or Location | n | | | | | t | 0d. Inside City Limits |
| | Me H | ctor | MD TALBO | PΤ | | EASTO | N | | | | | | 1 XYes 2 No |
| | # # 28 | Director | 10e. Street end Number | | | 10 | f. Zip Code | | | | 10g. Citizen of | What Coun | ntry? |
| | 7 wi | | 501 DUTCHMAN'S | LANE | | | 216 | 601 | | | US | A | |
| | dee F | Funeral | 11. Maritai Stetus | 12. Was Decedant B Armed Forces? | Ever In U,S. | 13. Was [| Decedent of i | Hispanic Ori | igin? (Spe | cify Yes or No- Ricen, etc.) | - 14. Ra | ce - Americ | |
| 0 | or th | | 1 ☐ Never Married 2 ☐ Married | 1 Yes 2 XX | lo | | as 21/201/No | | | niceri, etc./ | | ack, White, | |
| 21215-0020 | hours effer deeth with the Meryland turet, or flems 23s or 28s-f show at Exercities from the northed at | d by | 3 Widowed 4 □ Divorced | Year or Dates: | | | as ZAXVO | эреспу. | | | Speci | η: WH | ITE |
| 5 | 72 h inetu | Completed | 15. Decedent's Ed (Specify only highest gre | ducetion da completed) | 16e. | Decedent's | Usuai Occu | pation during mos | t of workir | na | 16b. Kind of I | 3usiness/Inc | dustry |
| 7 | filed within 72 Hygiene. Ither than "nat | idu | Elementery/Secondary (0-12) | College (1-4or 5 | | life. DO N | OT use retire | ed) | | | | | |
| N | Hygie ther th | | / | -0- | H | IOUSEW | IFE | | G. U.D. | | | HOME | |
| aryland | to do oth | Be | 17. Father's Neme (First, Middle, Last, | | | | | | | | Meiden Sume | me) | |
| 3 | should be filed within 72 hours efter deeth with the Merylen and Mentel Hygiene. s merked other than "naturel", or flems 23s or 28s-f show turnstic svent, the Medical Examiner must be notified. | 70 | | MOUR | | | | | THA | WARNER | | | |
| ā | 2000 | | 19a. Informant's Neme/Reletionship (JERRY C. WRIGHT / | | | _ | | | | | or, City or Town | n, Stete, Zip | Code) |
| a) | 1 end Heeith em 27 other tr | | | NEFILW | | | | KUAD, | EAST | ON, MD | | | |
| altimore, | 8 5 = 2 | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ | Removal from State | 20b. Place of cemater | | or other ple | ece) | i | Date | 20c. Location | | |
| | tant: | | 4 ☐ Donation 5 ☐ Other (Specific | y) | SPRING | HILL | CEME | rery | 2 | -3-00 | EASTON | , MD 2 | 21601 |
| Ba | permit. Peges 1 end Department of Health Important: If Item 27 any Injury or other tr 2009. | | 21. Signature of Funeral Service Licer | isee | | | OLIC T | | | S METAN | IAM PIINI | EDAT T | TOME |
| | 00 = 0 | | Joseph M. | Ostrowski | | | | | | | AM FUN | | HOME |
| г | | | 23a. Part1. Enter the disease, or com shock, or heert failure. List only | plications that caused one cause on each lin | the deeth. Do n | ot enter the | mode of dy | ing, such es | cerdiec o | r respiratory ar | rest, | | Approximate Interval Between |
| | Physician | | | | | | | | | | | - | Onset end Deeth |
| | /Medical Examiner | | Immediate Cause (Final disease or condition | a Bilat | vial F | Fron | Ron | neur | non | La. | | 7 | Incertain |
| | LAGITATIO | U | resulting in death) | | Due to (or es a c | | | | | | | | |
| | D iii | ine | | b | | | | | | | | 1 | |
| | aecut end -tran | Examiner | Sequentially list conditions, | | Due to (or as a c | onsequence | e of): | | | | | | |
| g Q | be ey ician burie | | if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury | C | | | | | | | | | |
| 68760 | the death certificate be executed y the ettending physician and sched for use as the bunel-transit | edicai | that initiated events resulting in death) Last | | Due to (or as a c | onsequence | of): | | | | | į | |
| × | eath certific ettending pl for use as f | 2 | L | d | | | | | | | | i | |
| 8 | etter for u | Physician | | | | | | | | | | | |
| o. | v requires that the de been signed by the should be deteched | ysi | Pert II. Other significant conditions of | ontributing to death bu | t not resulting In | the underly | ring ceuse gi | ven in Part i | i. | 23b. Did 1 | obacco use c | | the cause of death? |
| ٦. | thet the detection | 윤 | alpheiner ? | type de | mente | à | | | | 10 | Yes 2 No | 3 Prob | bably 4 Unknown |
| g Q | iaw requires thet es been signed b 2 should be dete | d by | Tardive dys | | | | | | | 040 14/00 | | 7 24h We | are autopru findings |
| Records, | requ | Completed | Tardine dys | kmesia | | | | | | perfo | en eutopsy rmed? | ave | ere eutopsy findings eiiable prior to mpietion of cause |
| ě | es 22 | ld m | | | | | | | | | | of c | deeth? |
| | : The cate h | | | | | | | | | 101 | res 2 No | 1 | Yas 2□ No |
| VITal | ysician: The s certificate director, pag | Be | 25. Was cese referred to medicel examiner? | Hospital: | | | 0. | | | (Check only o | | | |
| 6 | this dir | 2 | 1 Yes 2 No | 1 ∐ Inpatier | | |] DOA | | | | dence 6 □Ot | | y) |
| ב | ding Phy th. After thi funeral | lo | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injur (Month, Dey | Year) 28b. T | njury | 28c. Inju Wo | | | dd. Describe r | now Injury occu | rred | |
| 2 | death death tor: the | cat | 2 ☐ Accident investigation 3 ☐ Suicida 6 ☐ Could not be | | 444 | М | | Yes 2 | | 106 Landina /6 | Dancied a so of Advan | hair an Orran | / Davids Absorber |
| DIVISION | i or Attend efter death Director: / | Certification: | 4 ☐ Homicide determined | 28e. Place of Inju building, etc | . (Specify) | m, street, te | actory, office | | - | City or Tox | | per or Hure | of Route Number, |
| | pitai ours erai filled | | 29a. Certifier 1 Cartifying Ph | usialan. To the heat o | 4 mu languila dag | death seem | anned na Alexa A | | | and also has the a | | | |
| | To the Hospital or Attending Physician: within 24 hours effer death. To the Funersi Director: After this certificy completely filled in by the funeral director. | edical | (Check only one) | yaician: To the best o niner: On the basis of and manner sta | examinetion and | for investig | ation, in my | opinion, dee | oth occurre | ed et the time, | date end piace | , and due to | the ceuse(s) |
| | o the o the | Me | 29b. Signature and title of certifier | and mailiner sta | s writer | | 29c. Lican | se number | | Т. | 29d. Date sign | ed (Month. | Dey, Year) |
| | ⊢ ≱ ⊢ ŏ | | Robert W. | Trever | M.D | | | 0938 | 3 | | Jan. 3 | | |
| | | | 30 Neme and eddress of person who | | | Tune Dalast | | | | | 0 | | |
| | | | KOBERT TREVE | | 7690 | ED. | CAN! | GAT. | LIA | / / | FASTO | n mn | 21601 |
| | Sta | te | 31. Dete filed (Month, Dey, Yeer) | / 32. Registre | r's Signature | 1 | | | _0011 | L | _1010 | 1 | 1001 |
| | Registr | | FEB 0 2 2 | | Carp Bar | D. | door | Kel | | | | | |
| | | | 4 50 0 10 1 | , | | | - | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene 05051

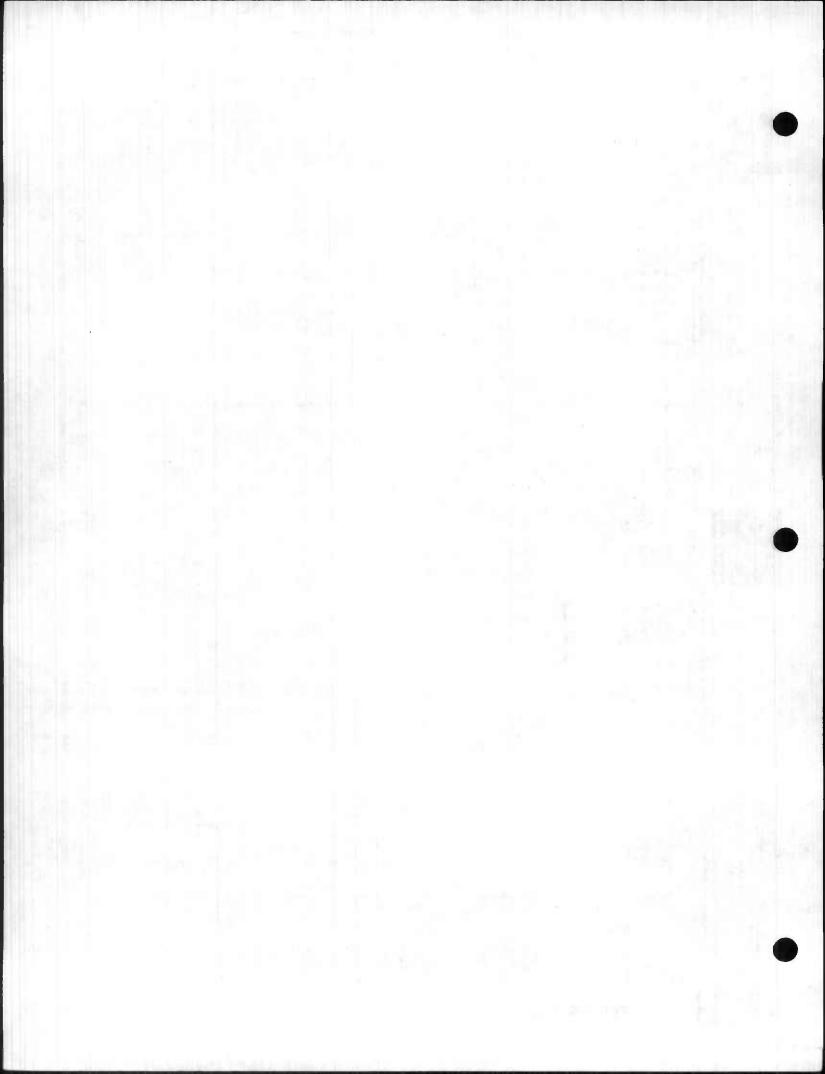
| JU. | -0011-0 | 33 | | tate of mary | | rtificate | | Death | | a. No. | 00 | UJI |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------|----------------------------|----------|---------------------------------------------|------------------------------------|-----------------------------------------|--------------------------------|------------------------------------|
| | _ | | Decedent's Neme (First, Middle, Last) | | | | | | 2. Date of Deat | h | | 3. Time of Death |
| J | Physici /Medic | | William E. Brow | n | | | | | Month FEBRUAR | Day Y 2, 20 | Year OOO | 1629 PM |
| | Examir | | 4e Facility Neme (If not Institution, give stre | | | | 1 | 4b. City, Town, or L | | 4c. County | | |
| | | | 2008 ENTERPRISE ROA | D | | | | MITCHEVI: | LLE | PRINC | E GEOI | RGES |
| | Funeral | | 5. Social Security Number 6. Sex | | yrs. last birthday, | Months | Year | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | | | ce (State or Foreign |
| | Director | | 579-12-6546 | ^{2□ F} 82 | Yrs. | INICHETIS | Days | Trous With | May 29 | 4 4 | Mary] | |
| | M M | | 10a. Stele 10b. County | 100 | City, Town or L | ocation | | | | | 10d | I. Inside City Limits |
| | the Meryland 28a-f show notified at | to | MarylandPrince Ge | orge M | itchel. | 1 v i 1 1 4 | 0 | | | | | Y□Yes 2□No |
| | 7 28 P | Directo | 10e. Street and Number | | | 10f. Zip C | | | 10 | g. Citizen of V | What Country | n |
| | 1 will | | 2000 Enterprise | Rd | | 21 | 071 | 16 | | U.S. | 7\ | |
| | atter death with the Merylar or thems 25e or 25e-f show miner must be notified at | Funeral | 11. Meritel Stetus 12. | Was Decedent Ever Armed Forces? | in U,S. 13. | | | lispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- | 14. Rac | e - American ck, White, etc | |
| 21215-0020 | hours after hursi', or its at Examins | by Fu | 1 ☐ Never Merried 2/2 Merried | 1 Yes 2 No If Yes, Give X Yeer or Detes: | | 1 ☐ Yes 2 | | Specify: | rical, etc./ | Specify | r | |
| ĕ | 2 hou | | 15. Decedent's Education | PERSONAL PROPERTY. | 16a, Dece | dent's Usual | Occur | pation | 1 | 6b. Kind of Bu | Blac | |
| 215 | n 72 | Completed | (Specify only highest grade co | | (Give | kind of work DO NOT use | done | during most of work | ring | | | |
| 2 | d within glens. or then | E | 1 2 | College (1-4or 5+) | Fai | rmer | | | | Agric | ultur | ~e |
| B | 1111 | Bec | 17. Father's Name (First, Middle, Last) | - | | | | 18. Mother's Nam | e (First, Middle, M | laiden Suman | 16) | |
| Maryland | Aental Aental riced of | TOE | Harry Brown | | | | | Julia C | hase Br | Own | | |
| ar, | of and | 7 | 19e. Informent's Neme/Reletionship (Type, | Print) | 19b. Meili | ing Address (| Street | and Number or Rui | | | State, Zip Co | ode) |
| | land 2 m 27 h her tra | | Eleanor Brown/Wi: | fe 2 | 000 Ent | terpri | ise | Rd, Mit | chellvi | lle M | D 207 | 16 |
| Baltimore, | -156 | | 20e. Method of Disposition | 20 | b. Plece of Dispo cometery, cre | osition (Name | 9 0/ | | | 20c. Location - | | |
| Ĕ | Pages nert of ent: If Ib ary or o | | 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Reme 4 ☐ Donation 5 ☐ Other (Specify) | | | | | eb.8,20 | nn s | uitla | nd MD | |
| alti | Parts Spirit | | 21. Servature of Edourel Service Licensee | -57 | | 2. Name and | | | 00 10 | ullia | nd ML | |
| m | 90 E 8 8 | | //w() & | | 191 2 | | - | | | 100 | | |
| | | | 23a. Pert 1. Enter the disease of complication shock, or heart tailure. List only one c | | teath. Do not en | ter the mode | of dyir | ng, such as cardiac | or respiratory arre | Aqu | , A | MD 20608 |
| | Physician | | shock, or heert tailure. List only one c | ause on each line. | | | | | | | i o | nterval Between Onset and Death |
| | /Medical | | Immediate Cause (Final disease or condition | ATHONOS | 1 1000 000 1 | . C 4 05 | Sus | A Scham | - OLL DAG | کـ | F | |
| | Examiner | | resulting in deeth) e | | to (or as e conse | | 010 | VI2 SCORIO | 0021108 | | | |
| L. | n # | nec | | | | 4 | | | | | 1 | |
| | cuter | me | Sequentielly list conditions. | Due | to (or as a conse | quence of): | | | | | 1 | |
| Ó | an a | E | Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | i | |
| 68760, | ificate be executed g physician and as the bunal-transit | edical Examiner | that initiated events resulting in death) Last | Due t | o (or es a consec | quence of): | | | | | 1 | |
| | E 0 E | | | | | | | | | | 1 | |
| Box | death cer e attendir ed for use | and | d | | | | | | | | | |
| | dea od fo | SICI | Pert II. Other algnificant conditions contribu | uting to death but not | resulting in the u | ınderlying cau | use giv | ven in Pert I. | 23b. Did to | bacco use co | ntribute to ti | he cause of death? |
| 0 | requires that the death cert een signed by the attendin hould be detached for use | / Physician/M | | | | | | | 1 🗆 Ye | 18 2□ No | 3 Probei | bly 4 Unknown |
| Records, | sign d be | Completed by | | | | | | | 24a. Was ar | n autonsv | 24b. Were | e autopsy findings |
| Ö | v require been si should | ete | | | | | | | perform | ned? | availe | able prior to pletion of cause |
| 36 | S 50 | E E | | | | | | | 1 | | of de | / |
| | ician: The certificata rector, pag | ပိ | | | | | | | 1 Ye | s 2□No | 167 | Yes 2□ No |
| Viital | lcian certif recto | Be | 25. Was case reterred to medical axeminer? | pitel: | | | Oth | | th (Check only on | | | |
| o | Physician: rthis certific iral director, | ٦. | XIX tes 2 No | 1 Inpatient | 2 ER/Outpatie | | | 4 Unursing no | ome 5 ☐ Reside 28d. Describe ho | | | AT SCENE |
| LO C | After | 5 | 1 ☑Neturel 5 ☐ Pending | (Month, Day Yea | r) Injury | м 200 | c. Injui | rk? Yes 2 □ No | EUG. DOSCINO IIO | w what y occur | 760 | |
| Sign | Attending or death. ector: Atter by the fune | cal | 3 Suicide 6 Could not be | Se. Piece of Injury - / | At home farm et | | | 160 2 2 100 | 28f. Location (Str | neet and Numb | ner or Rural F | Route Number |
| Division of | or Attending after death. Director: After din by the fune | Certification: | 4 Homicide determined | building, etc. (Sp | | reet, tectory, | OHICE | | City or Town | | or or moral r | source (various, |
| _ | pital pral filled | 2 | 29e. Certifier 1 ☐ Certifying Physicia | m. To the heat of m. | kanuladan dant | h annumed at | aha ali | no data and alone | and due to the en | woole) and ma | | and |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Fureral Director: After this certificate he completely filled in by the funeral director, page | edical | 29e. Certifier 1 ☐ Certifying Physicis (Check only one) 2 ☑ Medical Examiner: | | | | | | | | | |
| | thin the | M | 29b. Signature end title of certifier | and meaning stored. | - | 29c. | Licens | se number | 25 | 9d. Date signe | d (Month, De | ay, Year) |
| | F 3 F 8 | | MO15 1 | Maile | 911 | | | ME | | EBRUAR | | |
| | | | young you | Jewe (| , , , | | | | | ייייייייייייייייייייייייייייייייייייייי | | 1000 |
| | | | 30. Name end address of person who compl | | | | _ | De14-2 | | - 2 000 | 0.1 | |
| | 0: | | 31. Dete filed (Month, Day, Year) | 32. Reg/strar's S | | stree | τ, | Baltimore | e, Maryla | and 212 | OT | |
| | Sta Registr | | FEB 0 9 2000 | | | . 10 | ack | 2 | | | | |



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| r | CIVISTA | | | | | | | | | LATA | | CHAR | | |
| | 5. Social Security | | 6. Sex | | 7. Age (In y | s. last birthd | lay) If Und | der 1 Year | | 24 Hrs. | B. Date of Bi | rth | 9. Birthp | place (State or |
| I | 220-13-3 | | 10 | M 200 F | 22 | Yrs | i. Morier | is Days | nours | Nove | (Month, Di ember | 25, 1977 | Mary | land |
| | Usual Residence 10a. State | 10b. Count | ly | | 10c. | City, Town o | r Location | | | - | | | 1 | IOd. Inside City |
| | Maryland | Char | 100 | | Ta | Plata | | | | | | | | 1 Yas |
| ь | 10e. Street and N | | TCD | | LLO | Laca | 10f. 2 | Zip Code | | | | 10g. Citizen of | What Cour | ntry? |
| | 6940 Re | tiremen | nt Ro | oad | | | 2 | 0646 | | | | United | State | es |
| 1 | 11. Marital Status | | | 12. Was Dec Armed F | edent Ever in orces? | U,S. 1 | 13. Was Dec | cedent of I | lispanic Or an, Mexica | rigin? (Spec | ify Yes or Notican, etc.) | 0- 14. Rac Bla | ce - Americ | |
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| - | Elementary/Sec | | | College (| 1-4or 5+) | | ining | | | | | Special | Need | Work ' |
| 1 | 17. Father's Name | | , Last) | | | , | | | 18. Moth | er's Name | (First, Middle | , Maiden Surnar | | 11021 |
| | Fred J | . Borre | e11 | | | | | | Mari | lyn I | . Mill | Ler | | |
| | 19a. Informant's | | | | | 19b. M | lailing Addre | ess (Street | and Numb | er or Rural | Route Numb | oer, City or Town | , State, Zip | Code) |
| F | | . Borre | e11/I | Father | | Sam Place of Di | ensition (A | | | | Det- | 200 1 200 | Chart | State |
| | | 2 Cremetion | | emoval from | State | cometery, o | crematory o | or other pla | L | ebrua | ry 9, | 20c. Location 2000 | | |
| - | | 5 Other (| | , , , | / S | t. Cha | | | | 1 | | Indian | Head, | Maryla |
| l | 21. Signature of I | / Service | Z/ | // | | | Willi | ams F | ss of Facili unera | 1 Hom | e, P.A | A. | | |
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DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 0 5 3 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 5, 2000 2:14 AM Helen Catherine Ball 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown Months Days Hours Min. B. Date of Birth (Month, Day Year) 1912 Washington, DC 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1□ M 2Ŭ F 87 Yrs. 577-01-1780 Usuei Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Abell 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Van Ward Road 20606 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bieck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th Grade 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Battenfield William Mabel Anita Garner Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Lynn Denny (Niece) 8141 Cedar Run, Waldorf, Maryland 20603 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, Siale 20e. Method of Disposition 1 Buriel 2 □ Cremation 3 □ Removal from State 2/9/2000 Bushwood, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Sacred Heart Cemetery Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on sech lina. Approximata Intervai Between Onset and Death Immediate Cause (Finai nun disease or condition resulting in death) Due to (or as a consequenca of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Funeral

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumstic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or frem any Injury or other traumatic avent, the Neddell Evanded

altimore, Maryland 21215-0020

with the Maryland

death

Examiner attending physician and for use as the buriel-transit Physician/Medical signed by t þ Completed pege 2 : Be 9 funeral Certification:

certificate

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After

efter death.

24 hours e Hospital

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0

or Attending

Division of Vital Records, P.O. Box 68760,

certificate be

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in death) Lest Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case rafarrad to medical axaminer? 26. Piaca of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Daia of injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 27. Mannar of Death 28b. Tima of 1 Naturai 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 18 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

Medical

Avani D. Shah, MD 31. Date filed (Month, Day, Year)

snal

FEB 0 8 2000

30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print)

29b. Signature end titla of certifier

32. Registrar's Signature

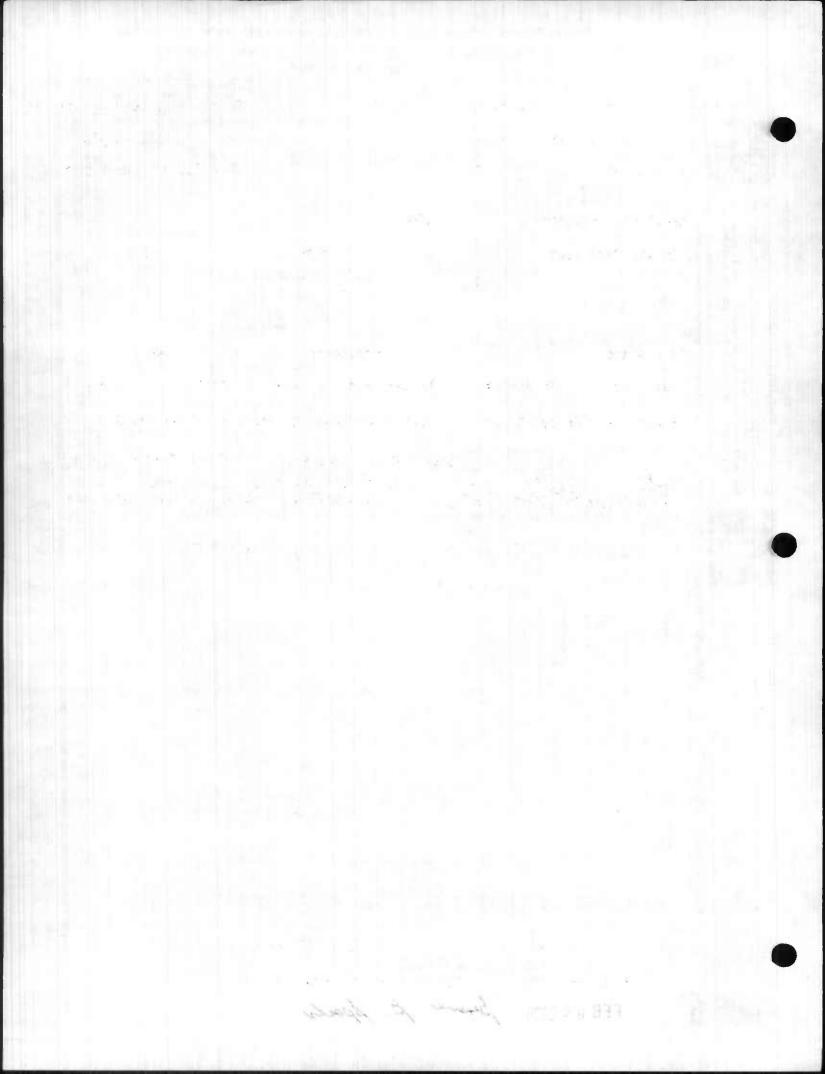
Leonardtown, Maryland 20650 ooch

29c. License number

D 47666

29d. Date signed (Month, Day, Year)

2-8.2000.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| ryland / Department of Health and Mental Hygiene | J | 5 | U | |
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| | edical | Michael | | Ky1e | | B1 | ankenship | | | JAN | | 5, 200 | | 1440 PM |
| Exan | miner | 4a Facility Nama (If not instituted 41700 COURT | | | | | 1 | 4b. City, To | WIN, OF LO | | eath | 4c. County | of Death | - |
| | | 5. Social Security Number | 6. Sex | | | | irthday) If Under 1 Year | | 24 Hrs. | -1111-111 | Birth | | | |
| Funer Direct | | | | 1 M 2 □ F 49 | | Yrs. | Months Days | Hours | | 8. Date of (Month) | | Year) 1950 | | Birthplace (State or Foreign Country) |
| D | .01 | Usual Residence of Decedent | | | 43 | | | | | July | 1/, | 1950 West Virginia | | |
| | | 10a. State 10b. Cour | nty | | 10c. City | , Town or Lo | ocation | | | | | | 11 | 0d. fnslde City Limits |
| Mar | Iner must be notified at | Maryland S | t. Ma | rv's | 1.6 | eonard | town | | | | | | | 1∰ Yas 2□ No |
| 1 28u | | 10e. Sfreef and Number 10f. Zip Code | | | | | | | | 10g. Citizen of What Country? | | | | |
| 3a o | 0 | 41700 Court H | 01150 | e Drive 20650 | | | | | United States | | | | | |
| deat | Funeral | 11. Marital Stafus | | 12. Was Decedent Evar in U,S. Armed Forces? | | | 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | | | ecity Yes o | r No- | 14. Rac | 14. Race - American Indian, | |
| or he | - | 1 Never Married 2 M | arried | 1 ■ Yas 2 □ No | | | | | | ricari, atc./ | | Black, White, etc. Specity: White | | |
| Sun Sun | by | 3 Widowed 4 Divorce | ed | Year or Dates: | | | 1 ☐ Yes 2 € No Specify: | | | | | | | |
| 72 hours "netural", | Completed | | lenf's Educi | ucation 16a. | | | a. Decedant's Usual Occupation (Give kind of work done during most of work | | | kina | | 6b. Kind of Business/Industry | | |
| c - | nple | Elementary/Secondary (0-12 | | College (1-4or 5+) | | | life. DO NOT use retired) | | | | | | | |
| 7 77 77 | S | | | 4 | | Fun | Funeral Director | | | | Funeral | | | |
| B B B | Be | 17. Father's Name (First, Middle, Last) 18. Mother's Na | | | | | | | er's Name | ne (First, Middle, Maiden Sumame) | | | | |
| Mer | | Auldie K. Blankenship Lilli. | | | | | | | | | | | | |
| N W W | | 19a. Informant's Name/Relation | onship (Typ | e, Print) | | 19b. Mailir | ng Address (Street | and Numb | er or Run | al Route N | umber, C | City or Town, | , State, Zip | Code) |
| 1 and Health am 27 | | Lillian R. Bl. | anken | ship/M | | 108 | Lilly St | reet, | Beck | | | | | |
| 8 0 | | 20a. Method of Disposition 1 ■ Burial 2 □ Cramatio | n 3 □Re | moval from S | C | | matory or other place | ce) | 1 | Date | 20 | c. Location | - City or To | wn, State |
| permit. Page Department o Important: If I | | 4 □ Donation 5 □ Other | (Specify) | _ | 12000 | ite Vi | sta Cemet | ery | 12 | -5-00 | B1 | uefiel | d. W | 7 |
| Department Personal Importan | Suce | 21. Signature of Funeral Service Ucerson 22. Name and Address of Facility Brinsfield Funera | | | | | | | | 1 Hon | ne, P.A. | | | |
| 8059 | a | Edward N. B | rinsf | ield. | MOO | | 2955 Holl | | | | | | | |
| | | 23a. Part1. Enter the disease, shock, or heart failure. L | or complic | ations that ca | aused the death | n. Do not ent | ter the moda of dylr | ng, such as | cardiac | or respirato | ry arres | 1, | 1 | Approximate Interval Between |
| Physicia | an | | act only only | 04000 0.100 | 401111101 | | | | | | | | | Onset and Death |
| /Medic | al | | | | | 1 | (| | | | | | 1 | |
| | 6 F | Immediate Causa (Final disease or condition | | | 5 | ton | vaula | f. on | | | | | | |
| LAUIIIII | | Immediate Causa (Final disease or condition resulting in death) | a. | | Due to (or | r as a consec | ugula quence of): | f. On | | | | | | |
| SIM | <u> </u> | disease or condition | a. | | Due to (or | | | f.on | | | | | 1 | |
| HILL | <u> </u> | disease or condition resulting in death) | a. | | 1022.27 | | quence of): | f. On | | | | | 1 | |
| 310 | <u> </u> | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury | a. | | 1022.27 | r as a consec | quence of): | f. On | | | | | | |
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State Registrar

31. Date filed (Month, Day, Year) FEB 0 8 2000

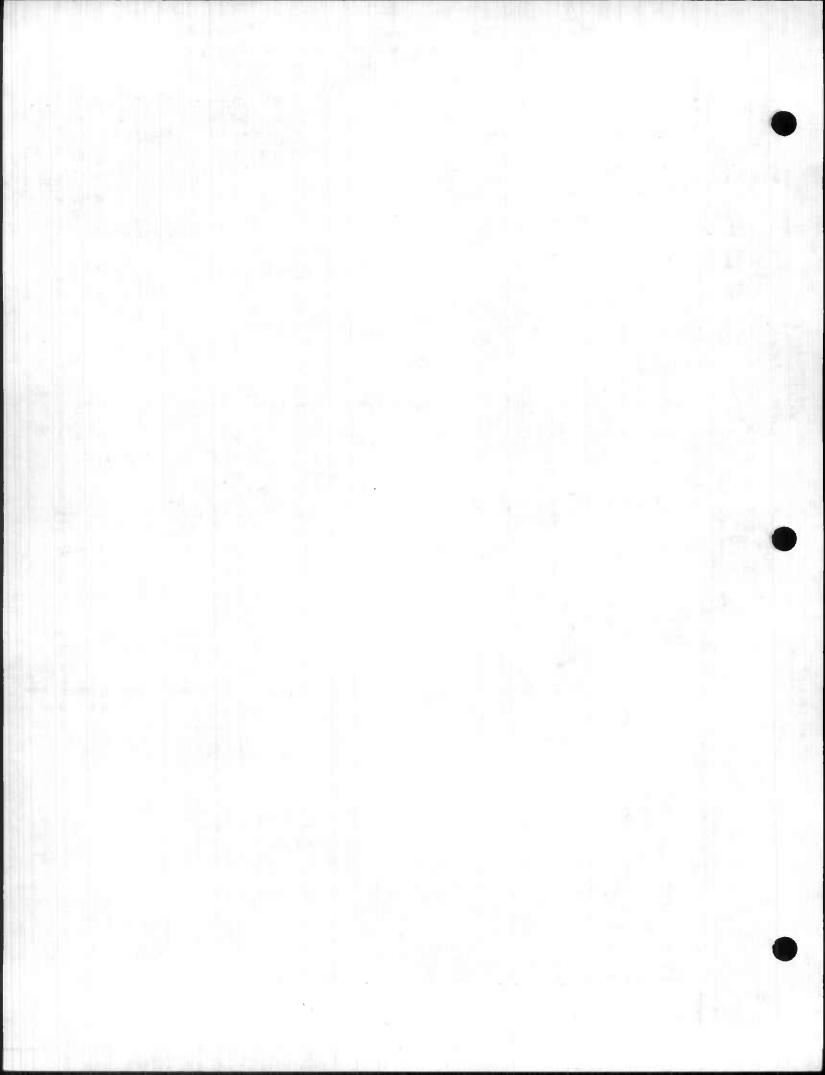
32. Begistrar's Signature

Spars,

FEBBERON Survey & Survey

| | | | | | Cei | rtificate c | of Death | | Reg. No. | CU | 055 | | | | |
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| htalaa | 1. Decedent's Name (First, | Middle, Las | t) | | | | | 2. Date of Do | | | . Time of Death | | | | |
| hysician /Medical | Cletus J | . Bl | ackwell | Jr. | | | | Janua | CZY Sex | 2000 1 | :30 P.M. | | | | |
| xaminer | 4a Facility Neme (If not ins | titution, give | street and numb | er) | | | 4b. City, Town, or | Location of Deal | th 4c. County | of Death | | | | | |
| | VALHES FORT | I OF AR | D DIVISI | OM | | | FORT FOW | CEL | BALT | IMORE | | | | | |
| neral | 5. Social Security Number | 6. Se | x 7. M 2□ F | Age (In yrs. la | | If Under 1 Ye | | | av. Year) | 9. Birthplace | (State or Foreig | | | | |
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| | Usual Residence of Decede | | | 10a Cina | . Town or Lo | a batan | | | | Tana | 1-14 60 17 9 | | | | |
| Man 1 | | | | | | | | | | 100. | Inside City Limits NOXYes 2 □ No | | | | |
| rector | | rford | | Abe | erdeen | | | | | | | | | | |
| G 25 | 10e. Streef and Number | | | | | 10f. Zip Cod | е | | 10g. Citizen of V | What Country's | 7 | | | | |
| | 401 Wyn-Max | r Aver | | | | | 001 | | U.S. | | | | | | |
| E E | 11. Meritei Status | | 12. Wes Decede Armed Force | es? | 5. 13. | Wes Decedent of If Yes, specify C | of Hispanic Origin? (Suban, Mexican, Puert | pecify Yes or No Rican, etc.) | 0- 14. Rac Biad | e - American ck, White, etc. | | | | | |
| b b | 1 Never Married 2 3 Widowed 1 Nover Married 2 1 Nover Married 3 Nover Married 2 1 Nover Married 2 Nover Married 3 Nover Mar | 1 | Yes 2 If Yes, Give Yeer or Dete | □No es: WWII | | 1 □ Yes 2√□ N | No Specify: | | Specify | White | | | | | |
| rt in Medical Ex | 15. De | cedent's Edu | ucation | | 16e. Dece | dent's Usual Oc | cupation | dia | 16b. Kind of B | usiness/Indust | lry | | | | |
| 90 | Elementery/Secondary (0 | | de completed) Coilege (1-4 | or 5+) | life. | DO NOT use rei | ne during most of wor tired) | rking | 33713 | | | | | | |
| dwo | 12 | , , | 0 | , | Elec | trician | | | Electr | cical | | | | | |
| Be Co | 17. Father's Neme (First, M | liddle, Last) | | | | | 18. Mother's Ner | me (First, Middle | , Maiden Suman | ne) | | | | | |
| To | Cletus J. 1 | Blackw | ell, Sr | • | | | | UNK | Barri | nger | | | | | |
| them 27 is marked other other traumatic avent, To Be C | 19e. Informant's Neme/Rei | etlonship (T | ype, Print) | | 19b. Meilii | ng Address (Stre | eet and Number or Ru | ral Route Numb | per, City or Town, | Stete, Zip Co | de) | | | | |
| 14. | Gladys Webb | (Compa | nion) | | 401 | Wyn-Mar | Avenue, A | berdeen | , Maryla | and 21 | 001 | | | | |
| other ti | 20e. Method of Disposition | | | 0.0 | ece of Dispo | osition (Name of | | Dete | 20c. Location - | | Stete | | | | |
| = 8 | 1 Buriel 2 Crem | | | ete | | | l Gardens | 2/4/00 | Aberdeer | Mary | land | | | | |
| Important: II any injury or once. | 21. Signeture of Fuperal Se | | | 1100 | | 2. Neme end Ad | | 2/1/00 | inci acci | if raily | Lana | | | | |
| any i | | 4/ | 00 | | | | Cargo Fune | eral Hom | e, P.A. | | | | | | |
| | Jonne | 14 1 | 3, Con | 50 | A | berdeen | , Maryland | 21001 | -3399 | 1 0- | | | | | |
| | 23a. Part1. Enter the disease shock, or heart feilure | List only o | Me ceuse on eac | h line. | . Do not ent | er the mode of t | dyrig, such es cardier | or respiratory (| errest, | Int | proximate erval Between aset and Death | | | | |
| ician dical | Immediate Ceuse (Final | | | | | | | | | 1 | | | | | |
| niner | disease or condition resulting in deeth) | | a. METAS | STATIC | RUVAL | CARCIN | OMA | | | 1 1 | year | | | | |
| | | | | Due to (or | as a consec | quence of): | | | | 1 | | | | | |
| Examiner | | | b | | | | | | | i | | | | | |
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| | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events | | C | | | | | | | | | | | | |
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| Physician/M | | | | | | | | | | Î | | | | | |
| bed /s | Part II. Other aignificant co | enditiona co | ntributing to deat | h but not resu | lting in the u | nderlying cause | given in Pert I. | 23b. Did | tobacco use co | ntribute to th | e cause of death | | | | |
| P de | | | | | | | | 1□ | Yaa 2 No | 3 Probab | ly 4 X Unknow | | | | |
| by by | | | | | | | | | | 1 | | | | | |
| Page 2 should | | | | | | | | | s an autopsy ormed? | availa | autopsy findings ble prior to | | | | |
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| рада 2 | | | | | | | | 10 | Yes 2 No | 1 D Y | es 2 No | | | | |
| ractor, pag | 25. Was case referred to m | edical | | | | | 26. Place of Dec | eth /Check on/v | one) | 1 | | | | | |
| 300 | exeminer? 1 ☐ Yes 2000 No | | Hospitel: Knp | atient 2∏ F | R/Outpatier | nt 3 DOA | Other | | idence 8 DOth | er (Specify) | | | | | |
| al dire | | | 28e. Date of | njury | 28b. Time of | | | · | how injury occur | | | | | | |
| erald | 27. Menner of Death | 1 Neturel 5 Pending (Month, Dey Year) Injury Work? | | | | | | | | | | | | | |
| e funeral d | 1 Neturel 5 □ F | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office | | | | | | 28f. Location | Street and Numb | ber or Rural R | oute Number, | | | | |
| by the funeral d | 1 Neturel 5 F 2 Accident 3 Suicide 6 C | Could not be | 28e. Piece of | injury - At not | | | | City or 10 | wn, Stete) | | | | | | |
| d in by the funeral d | 1 Neturel 5 F 2 Accident | | 28e. Piece of building | etc. (Specify, | 4 Homicide building, etc. (Specify) City or Town, Stete) | | | | | | | | | | |
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| completely filled in by the functed of Medical Certification: To | 1 Neturel 5 F 2 Accident 3 Suicide 4 Homicide 29e. Certifler (Check only 2 Me 29b. Signature and sittle of constant of the con | could not be letermined riffying Phy dicat Exami | building selclan: To the be iner: On the basi end menne | est of my knows sof examinetic steted. | riedge, deett on and/or in 23a) (Type, | 29c. Lice Print) | ly opinion, deeth occu |) | 29d. Date signe | d (Month, Day | e cause(s) | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death y 4, 2000 **Physician** February D 0210 Frieda Beate Bradley /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (Month, Day, Year)
Dec. 9, 1920 if Under 1 Year | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) West Germany 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🖾 F Yrs. 218-60-3721 79 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Directo MD Harford Aberdeen must be notif 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 167 Darlington Avenue 21001 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. Yes 2X No 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify.White þ 3€ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) UNK UNK Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 Karl Friedrich Kramer Frieda Freivolgel 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Mance (Nephew in Law) P.O. Box 305 Pembroke, Virginia 24136 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co, Inc. 2/7/00 West Chester, PA 21. Signeture of Furierel Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 mele 23a. Pert1. Enter the disease, or complications that caus shock, or heart feilure. List only one cause on each death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) Examiner Examiner the buriel-tran Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Physician/Medical Due to (or as a consequence of) US0 as signed by the atter Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Hmknown p 24b. Were autopsy findings evailable prior to Be Completed 24a. Was an eutopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 3 No 1 Yes 2 No director 25. Was case referred to madical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Panding investigation Injury 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 29e. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

To the Hospital within 24 hours e

The law requires that the deeth certificate be executed

Box 68760,

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of Vitai Records,

READLEY

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28a-f

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hours after

filed within 72 Hygiene.

. Pages 1 and 2 should be filtered of Health and Mental H tant: If Nem 27 ts marked off

Department of Important: If

and

physician

this certificate Physician:

Affer Attanding

death.

of Attand

Maryland 21215-0020

altimore,

TIME OF LEATH

State Registrar

31. Dete filed (Month, Dey, Year FEB

dgtagn

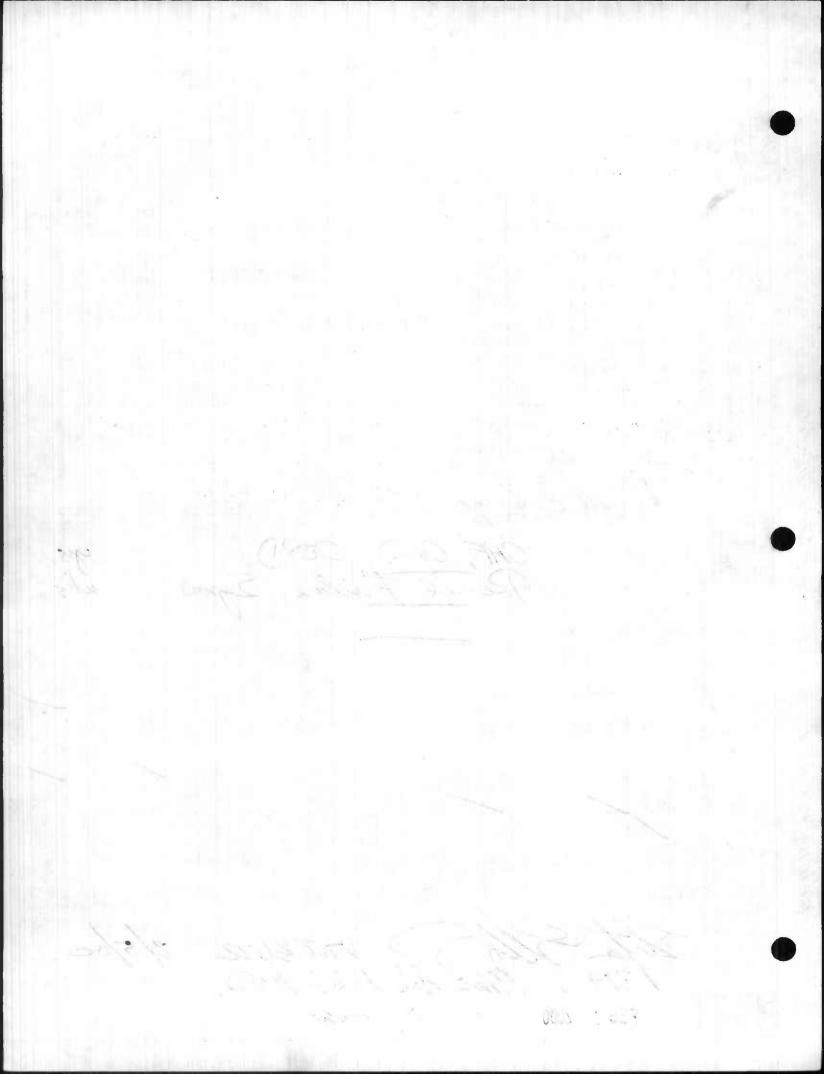
296.

2000

Registrar's Signeture

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29c. License number

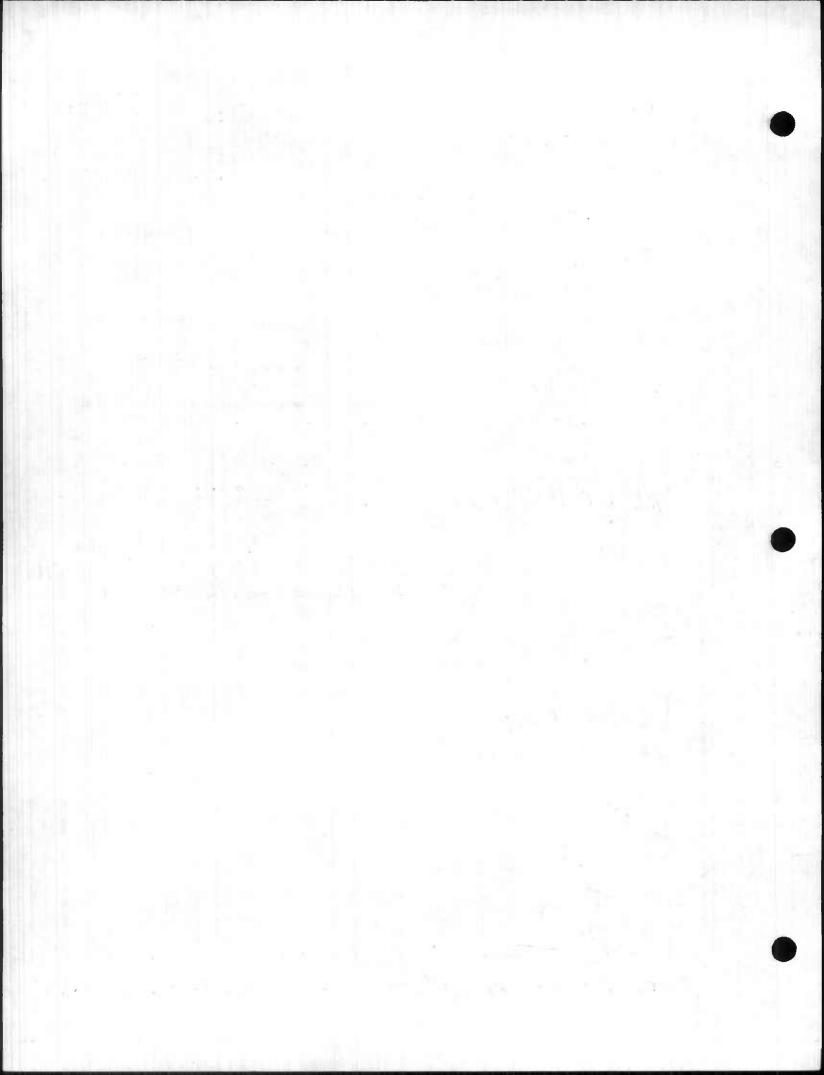
29d Date signed (Month, Dgr., Year)



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

| State of Maryland / Department of Health and Mental Hygiene | 00 | 0 | 5 | 0 | 5 |
|-------------------------------------------------------------|----|---|---|---|---|
| Certificate of Death Reg. No. | | | | | |

| | Certificate of Death | | Reg. No. | | | | | | | |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------|-------------------------------------------------|--|--|--|--|--|--|
| | 1. Decedent's Name (First, Middle, Last) | 2. Date of Dea | | 3. Time of Death | | | | | | |
| Physician | Floorer Massach Dockies | Month | | eer 12 40 | | | | | | |
| /Medical | Eleanor Margaret Bastian | Jan. | | 000 13:40 | | | | | | |
| Examiner | 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or L | Location of Death | 4c. County of | Death | | | | | | |
| | Harford Memorial Hospital Havre de | Grace | Harf | ord | | | | | | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Dete of Birt (Month, Day | | Birthplace (State or Foreign | | | | | | |
| Director | 184-07-6032 1 M 20 F 81 Yrs. Months Days Hours Min. | Feb. 16 | | Country) | | | | | | |
| | Usual Residence of Decedent | Treb. 16 | 1910 P | ennsylvania | | | | | | |
| 1 | 10a. State 10b. County 10c. City, Town or Location | | | 10d. inside City Limit | | | | | | |
| of all | Maryland Harford Bel Air | | | 1 □ Yas 2 🖾 N | | | | | | |
| 28a-1 notifie | Paryland narrord Ber Air | | | TO THE ZERI | | | | | | |
| be notified Director | 10e. Street and Number 10f. Zip Code | | 10g. Citizen of Wha | it Country? | | | | | | |
| | 434 Ellis Lane 21014 | | USA | | | | | | | |
| 10 | 11. Meritel Stetus 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (S) | necify Yes or No- | | American Indian, | | | | | | |
| iner must | Armed Forces? If Yes, specify Cuban, Mexican, Puerto | o Rican, etc.) | | White, etc. | | | | | | |
| | | | Specify: | White | | | | | | |
| fre d | 3 LYWidowed 4 LI Divorced Year or Detes: | | | MITCE | | | | | | |
| 1 5 | 15. Decedent's Education 16a. Decedent's Usuel Occupation | tring | 16b. Kind of Busin | ass/industry | | | | | | |
| Completed | (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (Elementary/Secondary (0-12) College (1-4or 5+) | Ning | | | | | | | | |
| 9 6 | Elementary/Secondery (0-12) College (1-4or 5+) 11 Homemaker | | Own Home | | | | | | | |
| | 17. Father's Neme (First, Middle, Last) 18. Mother's Nam | ne (First Middle | Maiden Sumame) | = | | | | | | |
| Be : | | | | | | | | | | |
| To E | Alfred (u/k) Aurisch Margare | t Anna | Marbach | | | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Ru | | | | | | | | | |
| 4 27 | Garret Garry-son-in-law 434 Ellis Lane, Bel A | ir, Mary | land 210: | 14 | | | | | | |
| tem 27 is other trac | 20a Mathod at Disposition 20b Place of Disposition (Name of | Dete | 20c. Location - Cit | | | | | | | |
| = 5 | 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State | 2/01/200 | 00 | | | | | | | |
| まる | 4 Donation 5 Other (Specify) Bel Air Memorial Gardens | 2,01,20 | BelAir | Maryland | | | | | | |
| mport any in | 21. Signature of Eugeral Service Licenses 22. Name and Address of Facility | D 3 | | | | | | | | |
| ESS | McComas Funeral Ho | | | | | | | | | |
| | 50 W. Broadway Str | eet, Bel | Air, Ma | | | | | | | |
| | 23a. Pent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart valure. List only one cause on each line. | or respiretory er | rest, | Approximete Intervai Between | | | | | | |
| hysician | | | | Onset and Death | | | | | | |
| /Medical | Immediate Cause (Final | | | iwa | | | | | | |
| xaminer | disease or condition resulting in deeth) a | // | | 1 1 | | | | | | |
| - b | Due to (or as a conference of): | /// | | monte | | | | | | |
| i i | rente venal | ellur | re. | 1 | | | | | | |
| in end hal-transit Examiner | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | | | | | | | | | |
| attending physician end for use es the buriel-transit clan/Medical Examir | thet initiated events | | | | | | | | | |
| Et D | resulting in death) Last | | | | | | | | | |
| Se s | d | | | | | | | | | |
| enficate has been signed by the attend solor, page 2 should be detached for us Be Completed by Physician/ | | | | | | | | | | |
| ed by the atterded for detached for Physicia | Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. | 23b. Did 1 | lobacco use contri | bute to the cause of deati | | | | | | |
| t iso | D. /· | 10 | Yes 2 No 3 | Probably 4 Dinkno | | | | | | |
| 9 4 | Vernentias | , , | 100 10110 0 | | | | | | | |
| 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 | | 0.41.141.77 | | 14h Mara autonou tindina | | | | | | |
| should should | 1/10/06/65 ////0/// | | an autopsy 2 med? | 24b. Ware autopsy tinding available prior to | | | | | | |
| 2 s b | Tragers fuelling. | | | completion of cause of deeth? | | | | | | |
| 4 8 E | | 100 | 000 | 4 🗆 Van - 0 🗆 Na | | | | | | |
| director, page 2 director, page 2 To Be Comp | | 101 | res 2 No | 1 Yes 2 No | | | | | | |
| B Schill | examiner | oth (Check only o | ne) | | | | | | | |
| al dire | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H | lome 5 Resid | dence 6 Other | (Specify) | | | | | | |
| the funeral cation: | 27. Manner of Death 28a. Dete of Injury 28b. Time of 1. Detect 1. | 28d. Describe I | now injury occurred | | | | | | | |
| funer | 1 Netural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No | | | | | | | | | |
| To the | 3 Suicide 6 Could not be | 28f Location / | Street and Number | or Rural Route Number, | | | | | | |
| led in by the funera Certification: | determined 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) | City or Tox | | or nural noble (vuriber, | | | | | | |
| 2 0 | | | | | | | | | | |
| To the Funeral Direct completely filled in by Medical Certifi | 29a. Certifier (Check only (C | , and due to the | cause(s) and mann | er as stated. | | | | | | |
| To the Funeral Director: completely filled in by the Medical Certifical | (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occur and manner stated. | rred at the time, | date and place, and | due to the cause(s) | | | | | | |
| M M | 29b. Signature and title of certifier 29c. License number | | 29d. Dete signed (/ | Month, Day, Year) | | | | | | |
| 6 | 1/2/1 | _ | | 0 - 4 | | | | | | |
| 1 | H.3907.2 | | duyava | 18 2007 | | | | | | |
| | 36 Name and address of person who completed cause of death (Item 23a) (Groe, Print) | | - / | ! | | | | | | |
| 1 | VENER / dlack DD 1308 BUSINES CM | UL F | dea | 2/11/15 | | | | | | |
| Ctot | 31. Date filed (Month, Day, Year) 32. Redistrar's Signature | my " | yewo | od Wy | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) 32. Redistrar's Signature | | | | | | | | | |
| | VIII LUUU / | | | | | | | | | |



| State of Maryland / Department of Health and Me | ental Hygiene | 05 | 05 | 8 |
|-------------------------------------------------|---------------|----|----|---|
| Certificate of Death | Reg No | | | |

Physician /Medical **Examiner**

JAMIE LEE BLAKE 4a Facility Name (If not institution, give street and number) 012nth Oly

2. Date of Death

Reg. No.

3. Time of Death 10:50AM

FT. WASHINGTON MEDICAL CENTER

1 □ M 2 X F

4b. City. Town, or Location of Death

4c. County of Death FT. WASHINGTON PRINCE GEORGE'S

2000

Funeral

376-10-4446 Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

10c. City, Town or Location

7. Age (In yrs. last birthday)

89

8. Date of Birth (Month, Day, Year) February 24,1910 Hours

 Birthplace (State or Foreign Country) Mississippi

10d. Inside City Limits

Director

show

"natural", or flams 23s or 28s-f

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event.

filed within 72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

à

Completed

80

10b. County Maryland Prince George's

Ft. Washington

1 Yes 2 No

10e. Street and Number

5. Social Security Number

301 Taurus Drive

10f. Zio Code 20744

Months

10g. Citizen of What Country? U.S.A.

11 Marital Status

1 Never Married 2 ☐ Married 3 ₩ Widowed 4 Divorced

 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 Ñ No Specify:

 Race - American Indian, Black, White, atc. Specify:

Black.

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12th

College (1-4or 5+)

Sales Clerk

If Under 1 Year | If Under 24 Hrs.

Days

Private

17. Father's Name (First, Middle, Last)

Andrew Edwards

18. Mother's Name (First, Middle, Meiden Sumame)

2000

Lelia Nesbit

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Taurus Drive, Ft. Washington, Maryland 20744

Ernest H. Blake/Son

20b. Place of Disposition (Name of cemetery, crematory or other place)

O2/10 20c. Location - City or Town, State

20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State

Lincoln Memorial Cemtery

Suitland, Maryland

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licenses

22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME

7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785

Physician /Medical Examiner

physician and the burial-transit

signed l

Hospital or Attending Physician: The law requires
 4 hours after death.
 Funeral Director: After this certificate has been sign

by

Completed

Be

Certification: To

edicai

that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Ver.

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Metista Due to (or as a consequence of):

Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximete Interval Between Onset and Death

1 Yes 2 No 26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

> 5 Pending investigation

6 Could not be determined

Hospital: 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

27, Menner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of castifies

245365

02-01-03

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Sidarous, M.D. 11701 Livingston Road, #101, Ft. Washington, MD 20744

State Registrar

filled in

To the Hosp within 24 hos To the Fune completely fi

3

31. Date filed (Month, Day, Year)

FEB 0 4 2000

32. Registrar's Signeture

FEB 9 4 2000 Some

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| * * | | | | | |
|-------------------|-----------------|--------|-----|--------|---------|
| State of Maryland | / Department of | Health | and | Mental | Hygiene |

| - | ,a | | | Cei | tificate of | Death | | g. No. | | | | | |
|----------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------|-------------------|-----------------------------|-------------------------------------------------------------------------|--|--|--|
| | Physician | Decedent's Neme (First, Middle, Las ESTHER MAE | BROWN | | | | 2. Date of Deat Month January | 20ay 20 | ở ô ar | 3. Time of Death | | | |
| ¥., | /Medical Examiner | 4a Facility Name (If not institution, give | | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | 7:20 A.M | | | |
| | | 3402 Nicholson S | | | | Hyattsvil | | Prince | | 0 | | | |
| | Funeral Director | 5. Social Security Number 6. Security Number 578-30-0753 | ox 7. Age 7. Age | (In yrs. lest birthdey) 84 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Dey, | | | iece (Stete or Foreign try) Lngton DC | | | |
| | wo m | 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | 1 | 0d. inside City Limits | | | |
| | Man a-f ah | Maryland Prince G | eorges | Hyattsvil: | le | , | | | | 1 G Yes 2 □ No | | | |
| | th with the Mai 23a or 28a-f a list be mosticed al Director | 10e. Street and Number 3402 Nicholson St | reet | | 10f. Zip Code | 20782 | 1 | _ | g. Citizen of What Country? | | | | |
| | 72 hours effer death with the Maryland natural; or items 23s or 28s-f show size in Examiner must be notified at each by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏗 Divorced | 12. Was Decadent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | In U,S. 13. Was Decedent of Hispanic Origin? (Spett Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ♣ No Specify: | | | | e - Americo k, White, | | | | |
| | n 72 hours natural', natural Figure | 15. Decedent's Ed (Specify only highest grad | | 16a. Dece | dent's Usual Occup | pation during most of worked) | ring | 16b. Kind of Bu | usin ass/In d | dustry | | | |
| 2000017 | | Etementery/Secondery (0-12) | Coilege (1-4or 5+ | 1 | | dry Dept. | | Prince | Georg | ges Hospit | | | |
| min June | Be doth | 17. Father's Name (First, Middle, Last) Arthur H. Gilbert | | Hana | 501 2001 | 18. Mother's Nam | e (First, Middle, I | | | | | | |
| - | mari mari | 19a. Informant's Name/Relationship (7 | Arthur H. Glibert Hattie Stitt An Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) | | | | | | | | | | |
| | od 2 lith a 27 h | Joan B. Scott- Da | ughter | 613 F | arragut : | St. , N.W | | | | | | | |
| | 0 0 | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Removal from State | | netory or other ple | | | 20c. Location - | | | | | |
| | pemit. Pag Department Important: I any injury o | 4 □ Donation 5 □ Other (Specify |) | Harmony | | | | | er, M | aryland | | | |
| | Departi Importu any inj | 1. Signature of Funeral Service Licensee 22. Name and Address of Facility eral Home, Inc. 4217 9th Street N.W. Washington DC 20011 | | | | | | | | | | | |
| | Physician /Medical Examiner | 23a. Psy11. Enter the disease, or compension, or heart feilure. List only of the limited at the | a. Pulmona | cy Maligne | ncy | | or respiratory con | 331, | | Approximate Interval Between Onset and Death | | | |
| ۰ | in d | | Chronic | Obstructi | ve Lump | Disease | | | i | | | | |
| | ificate be executed g physician and es the bunel-transit edical Examiner | Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): | | | | | | | | | | | |
| 5000 | | | | | | | | | | | | | |
| | attending for use | | | | | | | | 1 | | | | |
| | that the death cent ned by the attending detached for use y Physician/M | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause given in Part I. 1 Yes 2 No 3 Probably | | | | | | | | | | | |
| | aw requiras is been sign 2 should be pieted b | | | | | | 24e. Wes e perform | n eutopsy ned? | av | ere eutopsy findings aiteble prior to mpletion of cause deeth? | | | |
| | | | | | | | 1 🗆 Y | es 2KINo | 1[| Yes 2□ No | | | |
| | entific ector, Be | 25. Wes case referred to medical examiner? | Hospital: | | 0 | 26. Place of Dea | th (Check only or | (e) | | | | | |
| | hya ligi bis | 1 Yes 2 No 27. Manner of Deeth 1 Neturat 5 Pending | 28a. Date of tnjury (Month, Dey | 28b. Time o | f 28c. Inju | ury at ork? | ome 5 🙀 Reside 28d. Describe h | | | (y) | | | |
| | deat ctor: y the | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | | y - At home, farm, st (Specify) | | Yes 2 No | 28f. Location (S City or Town | | per or Rure | el Route Number, | | | |
| • | Hospi 24 hou Funer (taly fill | | ysician: To the best of liner: On the basis of e and menner state | xaminetion end/or in | | | | | | | | | |
| | within 2 within 2 comple | 29b. Signature and title of cartifier | | <u> </u> | 29c. Licen | se number | 2 | 9d. Date signe | d (Month, | Day, Year) | | | |
| | | 1 Dama | n. | (L | D-206 | 43 | | 02/02 | /00 | | | | |
| | (10) | 30. Name and address of person who d | completed dayse of dea | ath (Item 23e) (Type, | Print) | | | | | | | | |
| | 11 | Joseph B. Vaugh | n 6005 Lar | dover Roa | d, Cheve | rly, MD 2 | 0785 | | | | | | |
| | State | 31. Date filed (Month, Dey, Year) | 32. Registrar | 's Signature | | | | | | | | | |

DHMH 16 Rev 6/95

State

Registrar

FEB 0 4 2000

been the speece

2608 2 6 833

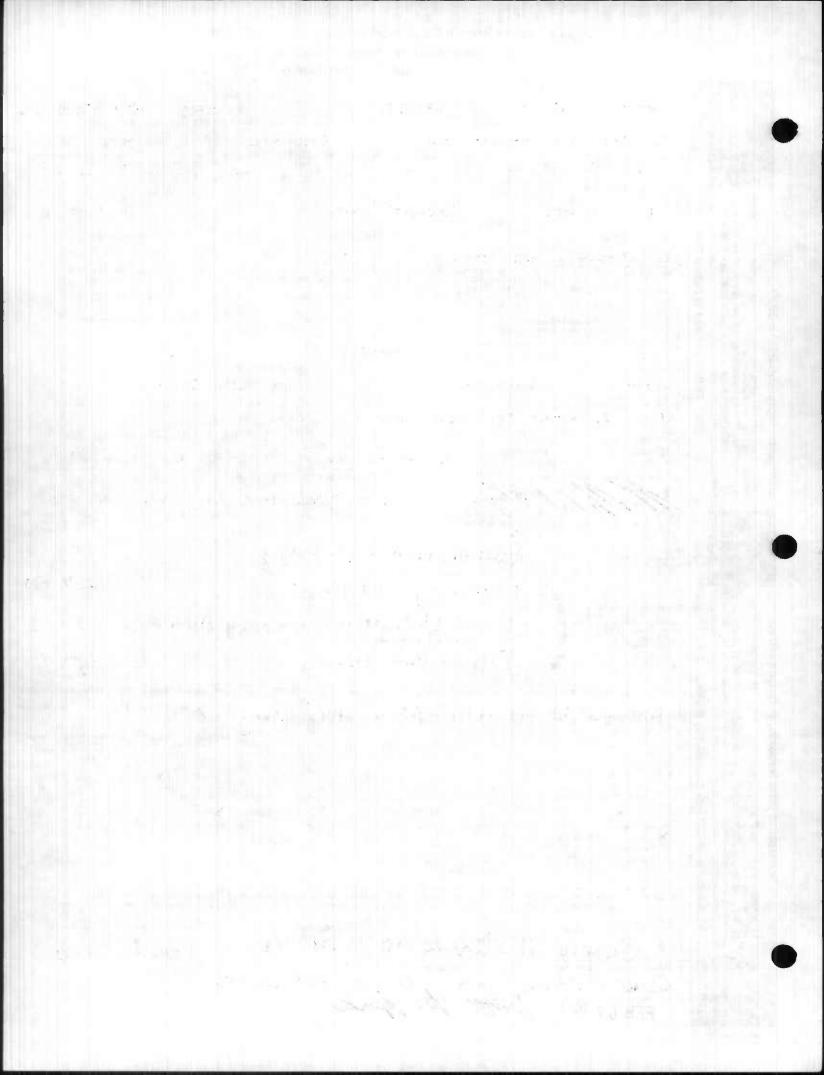
| | | | | | | Ce | rtificate of | Death | | Reg. No. | | | |
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| | 5 | | 1. Decedent's Neme (First, Middle, La | | | | | | 2. Date of Der | | Year | 3. Time of Death | |
| | Physicia /Medic | | Mary Louise | e E | Burns | | | | Februa | | 000 | 4:40PM | |
| | Examine | | 4e Facility Neme (If not institution, gir | e street and nu | nber) | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | | |
| | | | Southern Ma | aryland | Hospit | cal | | Clinton | n | Princ | e Geo | orge's | |
| | Funeral | | | Sex 1□M 2 0 F | 7. Age (In yr. | s. last birthday | If Under 1 Yea Months Day | | 8. Date of Birt | th v. Year) | 9. Birthp | lace (State or Foreign | |
| | Director | | 578-18-3555 | IUM AUF | 90 | Yrs. | | | Dec. 1 | 9,1909 | | yland | |
| | 2 | | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c C | City, Town or L | neation | | | | 1 | 0d. Inside City Limits | |
| | Agryla de | 5 | Maryland Calver | t. | 100.0 | | Frederi | ck | | | 1. | 1 ☐ Yes 2X No | |
| | 12 mm | Directo | 10e. Street and Number | | | | 10f. Zip Code | | 10g. Citizen of What Country? | | | | |
| | | | | | | | 101. ZIP C0008 | 20678 | U.S.A. | | | | |
| | na 23 | Funeral | 7050 Homela | 12. Was Dece | dent Ever in | U.S. 13 | Was Decedent of | | necify Yes or No | | e - Americ | can Indian. | |
| _ | D Per c | 5 | 1 Never Married 2 Merried | Armed Fo | rces? | 0,0. | If Yes, specify Cu | Hispanic Origin? (S ban, Mexican, Puert | Rican, etc.) | Blac | k, White, | | |
| Maryland 21215-0020 | | by | 3 □ Widowed 4 □ Divorced | If Yes, Giv | 9 | | 1 ☐ Yes 2 [X]N | Specify: | | Specify | Whi | ite | |
| Š | 2 hou | | 15. Decedent'e E | ducation | | 16a. Dece | dent's Usual Occ | upation | | 16b. Kind of Bu | usiness/Inc | dustry | |
| 215 | 2 | Completed | (Specify only highest grant Elementary/Secondary (0-12) | de completed) College (1 | -40r 54) | (Give | kind of work don DO NOT use retii | e during most of wor red) | king | , | | | |
| 2 | of the state of th | HO | 9th | N/A | 401 517 | | Sales | | | Depar | tment | t Store | |
| Pu | | Be | 17. Father's Nema (First, Middle, Last |) | | | | 18. Mother's Nam | na (First, Middle, | Maiden Sumam | e) | | |
| yla | Viet by Warrington | 0 | Thomas Sheeh | an | | | | Eliz | abeth | Pelkay | | | |
| lar | 2 sho and is ma | | 19e. Informent's Name/Relationship (| | | | | et and Number or Ru | | | | | |
| | and | | Patricia Edwar | rds (Dau | | | | eland Ct. | Prince | Frederi | ck, I | MD 20678 | |
| Baltimore, | of H liber of the orth | | 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Bemovel from | 20b. | Place of Disponentery, cre- | osition (Name of matory or other p | (ace) Febr | uary 4, | 20c. Location - | City or To | own, State | |
| Ē | Pag ment uny | | 4 Donation 5 Other (Special | | | esurrec | tion Cem | etery | 2000 | Clinto | n, Ma | aryland | |
| Salt | Post in the second | | 21. Signature of Funerel Service Lice | nsee | | | | ress of Fecility Le | | | | | |
| ш | 86168 | | 1 3th 5 6 | 5.44 | | | 6633 Old | Alexandr | ia Ferry | Road C | linta | on, MD2073 | |
| | | | 23a. Pert . Enter the disease, or correhock, or heert failure. List only | plicetions thet c | aused the dea | ath. Do not en | ter the mode of d | ying, such as cardiac | or respiratory as | rrest, | | Approximate Interval Between | |
| | Physician | | 1 | / | | | _ ^ | | , | | 1 | Onset and Death | |
| | /Medical Examiner | | Immediate Cause (Final disease or condition | + | + Ci | 00 | Dulm | mary | 1 Fdo | ana | 1 | 4 days | |
| п | | | resulting in death) | | Due to | (or as a conse | quence of): | 0 | | | | | |
| | D # | edical Examiner | | b | | | | | | | i i | | |
| | icate be executed physician and s the burial-transit | хад | Sequentially list conditions, if any, leeding to immediate | | | | | | | | | | |
| 68760, | be e ician buris | <u>e</u> | Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Cause (Disaese or Injury | | | i | | | | | | | |
| 587 | rificate be execut ng physician and es the bunal-tran | 8 | that Initieted evants resulting in death) Last | | Due to (| (or as a consec | quence of): | | | | 1 | | |
| Вох | certifi nding use ex | Ž | | d | | | | | | | | | |
| | The law requires that tha death ce te has been signed by the attendit page 2 should be detached for use | Physician/ | Pert II. Other algnificant conditions of | antillesting to de | | - Mii | | Constant Constant | 004 014 | | -0.40 . 0 . 0 | | |
| 0. | tha cy the ache | nys | | onthouting to de | LA | isularig in the t | nioenying causa (| / A | 10 | | | the cause of death? | |
| | ned to det | 2 | Canduac (1) | vrpys | hem | vac, (| onge | stine | | 2010 | 0 110 | outly 4 on the low | |
| Records, | aning on sig | 2 | 11. + 17 1 | 1 | | | 0 | | 24a. Was | an autopsy | 24b. W | ere autopsy findings | |
| 00 | aw rew | Completed | blar taus | w | | | | | peno | med? | CO | ailable prior to mpletion of cause death? | |
| æ | he lay | E | | | | | | | 101 | res 2000 | | N/A | |
| ta | certificate rector, pag | 9 2 | 25. Was casa referred to medical | | | | | 26. Place of Dea | | -22 | | 3 163 2 2 160 | |
| 5 | Physician: rthis certific ral director, | 0 | examiner? | Hospitel: 1/94 | npatient 2[| ☐ ER/Outpatie | nt 3 DOA | ther | ome 5 ☐ Resid | | er (Snecil | WI | |
| Division of Vital | Attending Physician: The isr death. ector: After this certificate he by the funeral director, page | | 27. Mannar of Death | | of Injury h, Day Year) | 28b. Time o | | | | now injury occum | - | ,, | |
| 0 | Attending or death. ector: After by the fune | atio | 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation | | ii, Day Fear) | Injury | | Yes 2 No | | | | | |
| VIS | Arte ecto | | 3 Suicide 6 Could not b | 286. PI608 | of Injury - At i | homa, farm, st | reet, fectory, office | 9 | 28f. Location (S City or Tox | | er or Rura | al Route Number, | |
| | a after al Direct ad in by | Certification: | | Odilon | ig, atc. (Spac | | | | Only or 100 | vii, Otaloy | | | |
| | lospi Lhou uner uner | edicai | 29a. Certifier 1 Certifying Ph | ysician: To the | best of my kn | owledge, deat | h occurred at the | time, date and place, opinion, death occur | , and due to the | cause(s) and ma | nner as st | tated. | |
| | | | one) | and mann | er stated. | | | | | | | | |
| | T × it | 2 | 29b. Signature and title of certifier | 1 -1 | 1.0 | | 29c. Licer | nse number | 711 | 29d. Date signed | J (Month, | Day, Year) | |
| | (| | Sam | Jel | 19 | w | 1). | 5421 | 4 | 5.1 | , 2 | 000. | |
| | (5) | | 30. Neme and address of person who | completed caus | of death (fte | om 23a) (Type, | Print) | ++ / | 20 01 | A 11. | 10 | 10720 | |
| | | | 31. Date filed (Month, Day, Year) | awi I | () | 100 | 5 Du | ralls R | a. Clin | DON IV | a. o | (0/35 | |
| | State Registra | | FEB 0 4 2000 | | egistrar's Sign | iaiUra | 1 | | | | | | |
| | negistia | | TED U 4 LUUU | 1 | A STATE OF THE PARTY OF | 123 | 400, 0 | | | | | | |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Betty BARRETT Alberta February 3 2000 12:20 a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) **Examiner** Chesapeake Beach Road East Calvert 7. Age (In yrs. last birthday) 5. Social Security Number 215 20 4028 9. Birthplace (State or Foreign Country)
Wash., DC **Funeral** 1□ M 2□XF Yrs. Director Usual Residence of Decedent with the Manyland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Wed rall Example marks in cities and once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Calvert Chesapeake Beach 1 Yes 2 No Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 3337 Chesapeake Beach Road East 20732 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward G Robertson Crowe Anna Marie 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William K. Barrett, Sr. (husb) same as 10 above 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 12 Burlal 2 Cremation 3 Removal from State 2-9-00 MD Veterans Cemetery Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** 1996 Immediate Cause (Final disease or condition resulting in death) /Medical Examiner 2-4 mos metus tuses Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Obstructive Pulmonary P.O. Box 68760. Physician/Medical as I ears O bacco Use use ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Rheumatord Arthritis - Rheumatord Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an eutopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes cese reterred to medicel examiner? 26. Piece of Death (Check only one) Other: 4☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Netural 5 Pending after deeth. 1 Tyes 2 TNo Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours edicai 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D17245 Feb. 3 25 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) DWINGS Md 20736 32. Registrar's Signarde 31. Dete filed (Month, Day, Year) FEB 0 7 2000

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dala of Death 3 Time of Death Vaer Month JUSEPH Feb 11:35 PM CHEW 02 2000 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Bultimone E Baitimore VA Medical Center CITY. Baltimore County Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 ■ M 2 □ F Months Hours Yrs 215 26 2955 Maryland 06/05/1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 819 Appleton Street 12. Was Decedent Ever in U,S.
Amed Forces?

1 ⊠ Yes 2 □ No 1952 −
If Yes, Give
Yaar or Dates: 1953 14. Race - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Salvation Army 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Reynolds **Blake** Chew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 819 Appleton Street Baltimore, MD 21217 Stella Chew/Wife 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 N Burial 2 □ Cramation 3 □ Removal from State 2/9/00 Port Republic, MD Solid Rock Church 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatura of Funeral Service Licensee Sewell Funeral Home > Bladye a. Servell 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BUCTERIAL SEPSIS disease or condition resulting in death) Due to (or as a consequence of): Choiceystitis Due to (or as a consequenca of): Due to (or as a consequence of):

Physician /Medical Examiner

The law requires that the death certificate be executed

ed by the e

signed by t

as been signal 2

certificate has birector, page 2 s

After this funeral

hours after death.

An 24 hour.

within 24 hor To the Fune completely li

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Completed

8

2

Certification:

edicai

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Hospital

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified ence.

altimore, Maryland 21215-0020

Physician/Medical Examiner ettending physician end for use as the burial-transit Sequentially list conditions, it any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY Atherosclerotic Disease

23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

1 Yes 2 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28d. Describe how injury occurred

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28b. Time of Injury 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Akom

5 Pending investigation

6 Could not be determined

29c. License number PI 3355

29d. Date signed (Month, Day, Year) 02/03/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28e. Date of Injury (Month, Dey Year)

UMMC. 225. Green St. Baltimore, Mb 21201 MIKE AKOM MU of Internal Medicine 31. Date filed (Month, Day, Yeer)

State Registrar

FEB 0 7 2000

1 le

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

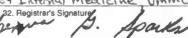
2 Accident

3 ☐ Suicide

29a. Certifie

4 T Homicide

(Check only



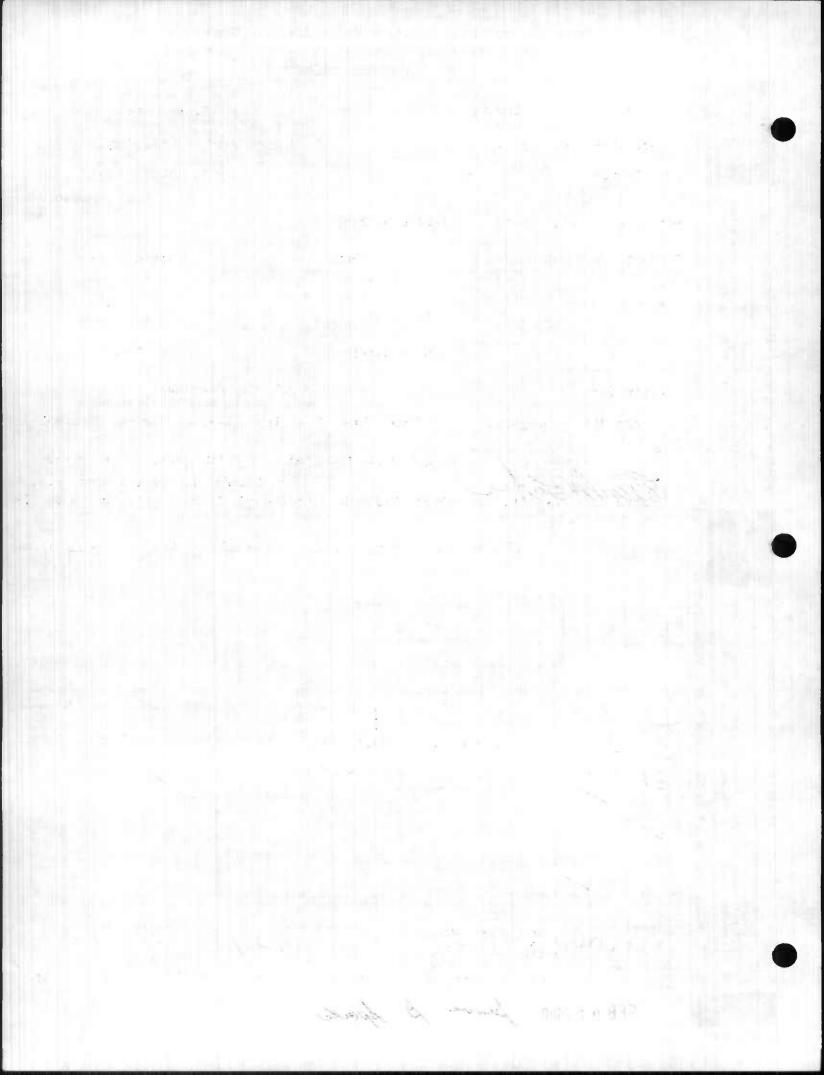
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State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 5 3

| | | | | | Olato of I | riai y iai | | Certificate of | | | | Reg. No | 00 | 15063 | |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------------------------------------------------------------------------|----------------------|-----------------------------------|--------------------|-----------------|-----------------------------------------------------------------------|---------------------|-------------|--------------------------------|---------------|-------------------|------------------------------------------|-------|
| | | | 1. Decedent's Name | First, Middle, L | .ast) | | | | | 1: | 2. Dete of Dea | ath | | 3. Tima of Dea | ath |
| | Physiciar ' /Medica | | Lillie | | Count | s | | Connor | | J | Month anuary | 28 | | 6:53 p. | m. |
| | Examine | | | not institution, g | ive street and numb | | | | 4b. City, To | | ation of Deeth | | . County of Dea | | |
| | | | 21057 Th | ree Not | ch Road | | | | Lexin | eton | Park | | St. Mar | v's | |
| | Funeral | | 5. Social Security N | | Sex 7. | Age (In yrs. | last birth | dey) If Under 1 Yea Months Dey | r If Under | 24 Hrs. (| 8. Date of Birt (Month, Day | | | thplace (State or Fo | reign |
| | Director | | 232-30-28 | | 1□M 2■F | 90 | Y | s. | | | uly 8, | | | orgia | |
| | pu . | - 1- | Usuel Residence of 10a. State | 10b. County | | 10c Cit | ly Town | or Location | | | | | | 10d. Inside City Li | lmite |
| | faryle | - 1 | | - Act | | | | | | | | | | 1 ☐ Yes 2 | |
| | the N | Director | Maryland 10e. Street and Nun | | Mary's | _ Le | exing | gton Park | | | | 10a Ci | tizen of What Co | nuntra/2 | |
| | with with | | | | | | | | | | | | | | |
| | r items 234 | 20 | 21057 Thr | ree Notc | h Road 12. Wes Decede | nt Ever in U | S | 20653 | Hispanic Ori | inin? (Spec | ify Yes or No- | United States | | | |
| | Herd | 5 | 1 Never Marrie | ed 2□ Married | Armed Force | s? | ,0. | Wes Decedent of If Yes, specify Cu | | | ican, etc.) | | Black, Whit | | |
| 020 | urs after death with the Marylen at, or items 23a or 28a-f show Examinat naus be notified at | 2 | 3 Widowed | | If Yes, Give Year or Date | | | 1□ Yes 2 N | Specify: | | | | Specify: W. | hite | |
| 21215-0020 | | Completed | (0) | 15. Decedent's l | Education | | 16a. E | Decedent's Usuai Occ Give kind of work don ife. DO NOT use reti | upation | A ad | | 16b. F | (Ind of Business | /Industry | |
| 215 | hin 7 | 2 | Elementary/Secon | ify only highest g | College (1-4) | or 5+) | - 9 | ife. DO NOT use reti | e aunng mos red) | or working | | | | | |
| | d will | 5 | | 3 | | <u> </u> | Sho | e Repair | | | | Sh | oe Repa | ir | |
| pu | d oth | 0 | 17. Father's Name (| First, Middle, Las | 51) | | | | 18. Mothe | er's Neme (| (First, Middle, | Meide | Sumeme) | | |
| Maryland | d 2 should be filed within 72 ho h and Mental Hygiene. 7 is marked other than "natur treumatic event, the Medical TO Be Commission | 2 | Abram (| Counts | | | | | Sara | h Alm | na Blac | kbu | rn | | |
| lar | 2 sho | | 19e. tnformant's Na | me/Relationship | (Type, Print) | | | Mailing Address (Stre | | | | | | | |
| | f Heelth fem 27 other tr | 2 | | | Daughter | 1 | | 057 Three | Notch | Road, | | | | | |
| ore | SET | | 20a. Method of Disp 1 Burial 2 D | | ☐Removal from Sta | | cemetery, | Disposition (Neme of crematory or other p | lace) | i | Date | 20c. L | ocation - City or | Town, State | |
| altimore, | artments ortant: injury | | 4 Donation | 5 ☐ Other (Spec | oify) | | adow | Ridge Mem | orial | 2- | -1-00 | E1k | ridge, | Maryland | |
| Bal | permit, Peges 1 end Department of Heelth Important: If item 27 any injury or other to price. | | 21. Signalate of Full | neral Service Lice | enses A | | | 22. Name and Add | ress of Fecili | y Bri | nsfiel | d F | uneral | Home, P.A | |
| | 00500 | | Edward | | sfield, J | r M00 | 052 | 22955 Hol | 1ywood | Road | l, Leon | ard | town, M | D 20650-0 | 279 |
| | | | 23a. Pert1. Enter the | e disease, or co | mplications that cause on each | sed the deat | th. Do no | t enfer the mode of d | ying, such as | cardiac or | respiratory en | rest, | | Approximate Interval Betwee | n |
| | Physician | | | | 0 0 | | | 0 | | | ilev | | | Onset and Deat | h |
| | /Medical Examiner | | Immediate Cause (I | Final 1 | e. Ch | ren | . « | reona | | 11 | cee | | | 44 | يس |
| | SECTION AND IN | | resulting In death) Due to (or as a consequence of): | | | | | | | | | | 0 | | |
| Ξ | nsit a | Evaluate | | | b | | | | | | | | | | |
| , | ifficate be executed g physician and es the buriel-transit | Y | Sequentially list cor if any, leading to im cause. Enter Under Ceuse (Diseese or I | nditions, mediete | | Due to (d | or es e co | nsequence of): | | | | | | t | |
| 68760, | ficate be physicial street buri | | Ceuse (Diseese or I | Injury | C | Due to (e | v 06 0 00 | nsequence of): | | | | | | | |
| | g phy es th | | resulting to death) L | .ast | | 0) 01 60 (0 | n as a co | nsequence or, | | | | | | | |
| Box | at the death certical by the ettending etached for use etached for use Dhysician M | 200 | | | d | | | | | | | | | | |
| | The law requires that the death certained has been signed by the ettending page 2 should be detached for use | 200 | Part II. Other signifi | cant conditions | contributing to death | n but not res | ulting In 1 | he underlying cause (| given in Part | l. | 23b. Did t | obacc | uss contribut | to the causs of d | eath? |
| P.0 | by the | | (D) 5 | hoso | - Box | vel | | Symas | one | | 10 | Yss : | 2 DN0 3 □ P | robably 4 Uni | nown |
| | es the ded | 2 | | , 50- 00 | ~ | | | | | | 1 | | | | |
| Records, | The law require rate has been si pege 2 should I | 3 | (2) | manl | in 2 | apen | and | 2 Did | eels | Mel | 1244 Was perfo | en euto | opsy 24b. | Were autopsy findi svallable prior to | |
| ec | hes be | 2 | | 200 | 1541 54 | 20 | | 0220 | 000 | | | | 1 | completion of caus of death? | В |
| E . | | 5 | (3) | -oren | 3 20 | sur | 5 | The state | W_ | | 101 | es i | tano | 1 ☐ Yes 2 ☐ No | |
| Vital | Physician: The rubis certificate ral director, peg | | 25. Was case referr | ed to medical | | | | | | e of Death | (Check only | 10) | 100 | | |
| of | hys all di | - | 1 ☐ Yes 2 | | | atient 2 | | atient 3LI DOA | | | | | 6 □Other (Spe | ecity) | |
| n | After funer | 5 | 27. Manner of Deeth 1 Neturel | 5 Pending | | njury Day Year) | 28b. Tir Inj | ury W | | | 8d. Describe h | now inju | iry occurred | | |
| Sic | Attend or death ector: , by the | 2 | 2 ☐ Accident 3 ☐ Suicide | Investigati | be on the state | taire. At h | | | □Yes 2□ | NO | of Location / | Street | nd Number or B | ural Route Number | |
| Division | tal or Attending P rs efter death. al Director: After t ied in by the funera | 5 | 4 Homicide | determine | | etc. (Specil | | n, street, factory, offic | 8 | 20 | City or Tox | vn, Stel | (e) | urai rioute riumber, | 4.5 |
| | ours ours filled | | 29a. Certifier | 1 Cartifying F | Physician: To the be | st of my kno | wladge | deeth occurred at the | time date en | d plece ar | nd due to the | causali | s) and manner a | s stated | |
| | To the Hospital or Attending Is within 24 hours elter death. To the Funeral Director: After completely filled in by the funeral Medical Certification. | | | 2 Medical Exa | miner: On the basis and manner | of examine | tion end/ | or Investigetion, In my | opinion, dee | th occurre | d et the time, | date en | d place, and du | e to the cause(s) | |
| | Vithin Fo the | 100 | 29b. Signature end | title of certifier | a 1V | 12 | | 29c. Lice | nse number | | | 29d. D | ate signed (Mon | | |
| | | | PAT | muy | illand. | RA | المرا | - 3 | 194 | 12 | 7 | | 2/1 | 2000 | |
| _ | | | 30. Name end eddre | ess of person who | completed cause | of death (tter | V23a) (T | ype, Print) | 9 | | 5. | 2 | m 11 | 1 2017 | - |
| 6 | | | | 103 1 | | 0 000 | AL | ROAD. | In | nee | med | | , 1017 | 20678 | 5 |
| | State | | 31. Date filed (Mont | h, Dey, Year) | 32. Regi | strar's Signe | eture 4 | 1 | , | | | | | | |
| | Registrar | | ret |) II 7EH | 160 | | | DOOK | 21 | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Charles Eugene CopElANd Physician 25 00 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAULE de Grace HARFORD MEM. HOSPITAL HARFORD ff Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Y 5. Social Security Number 6. Sex 120 M 2□ F 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 215-34-5705 63 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location ahow 10h County 10d. Inside City Limits HARFORD BELAIR 1 Yas 28 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 700 SEIKIRK CT Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 K Yas 2 No 1958
If Yas, Give Yaar or Datas: 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ther any injury or other traumetic event, the Medical Examina-1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specity: BIACK à 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Church 12 4+ MINISTER 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Fugene Cope / AND

19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Capeland
20a. Mathod of Disposition 700 SelKiRK CT Belair MO 21015 WIFE 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) LARKS UNITON 1-29-00 Moth 22. Nama and Addrass of Facility
BEARD FUNETAL HOME 21. Signature of Funaral Sarvice Licensee Risa Scatt 23a. Part1. Entar tha disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. 21078 Approximate Interval Batween Onset and Death **Physician** SEPSIS. /Medical Immediata Causa (Final disaasa or condition rasulting in daath) G-RAM-NEGATIVE 15 DAYS Examiner Due to (or as a consequence of): 15 DAVS Physician/Medical Examine 15CHEMIC COLON Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? INSULIN-DEPENDENT DIABETES MELLITUS 1 Yes 22No 3 Probably 4 Unknown CATHETER- SEPSIS. 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminar?
1 Yes 24 No Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Donpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) this 27, Manner of Death 28a. Data of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Affer Division or Attending 5 Pending invastigation Netural 2 Accident 124 hours after death. • Funeral Director: Af pletely filled in by the fu 1 Yas 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and due to the cause(s) and manner stated. edical completely (Check only one) To the F within 2. 29b. Signatura and titla of certifiar 29d. Data signed (Month, Day, Year) Andrew Nowaligans D08096 30. Nama and address of parson who completed causa of death (Item 23a) (Type, Print)

ANPREW NEWAKOWSKI WD.

DHMH 16 Rev 6/95

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Registrar

State

31. Data filed (Month, Day, Year) FEB 1

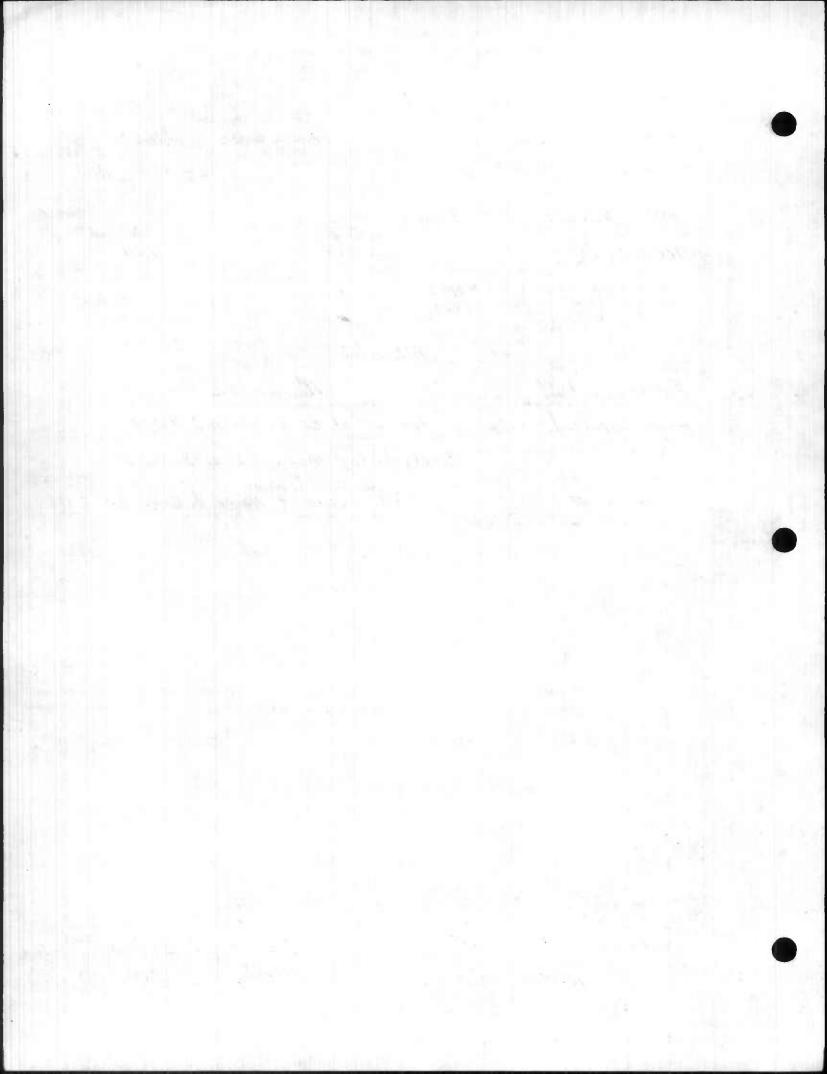
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32. Registrar's Signatura

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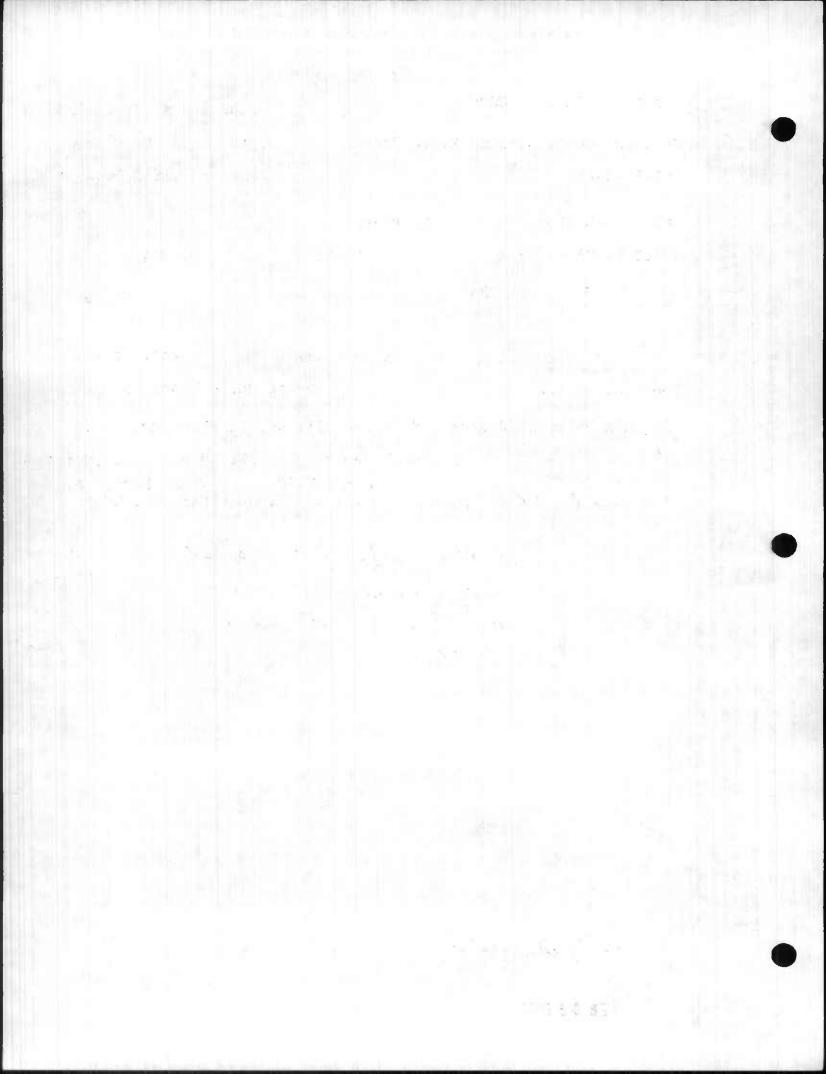
25 N. MANN ST. BEZMK, MD21014



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deeth Month **Physician** IDA BELLE COOK 7, 2000 February 1:50 PM /Medical 4b City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Charles County Nursing Rehab Center Charles La Plata If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X F Yrs. 267-50-5441 Usuel Residence of Decedent Director January 4,1913 Georgia death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Eractiver must be notified at 1X Yes 2 No Director Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 La Plata Road 20646 USA Funeral 12. Was Decedent Ever In U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: if Nem 27 is marked other than "natural", or Nem any Injury or other traumatic event, the Medical Era interpolate. 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify:White þ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Dept. Store 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Addie Belle Tison Henry C. Bivins 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Walnut Hill Rd. La Plata, MD. 20646 be of Disposition (Name of Dete 20c. Location - City or Town, State Virginia Parbuoni/Sister 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State National Cemetery 2/11/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tallure. List *on*ly one cause on each line. P.O. BOX 567 LA PLATA, MD. 20646 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical hous Due to (or es a consequence of): Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last for as a consequence of) Division of Vital Records, P.O. Box 68760, curio Due to (or as e consequence of): ed by the a 23b. Did tobacco use contribute to the cause of deeth? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed peen cartificate has b 1 Yes 2 1 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28h Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Aftar 1 Watural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: / 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 I Homloide within 24 hours after To the Funeral Dire completely filled in b 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e di 29b. Signature and title of cartifie 10 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) POBOX460 LAPLATA MD 20646

mE

Registrar



WILLIAM CHAPMAN

| н | Dhysisian | Decedent's Name (First, Middle, I | .ast) | | | | | 2. Date of De Month | path Dev | Year | 3. Time of Death |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------|-------------------------------------------------------|---------------------------|------------------------------------|------------------------------------|-------------------------------|-------------------------|---------------------------------------------------------------|
| | Physician /Medical | William | Alexander | Cha | pman | | | January | | | 8:20 p.m. |
| | Examiner | A . FT . OLD B AND A. T. AND A. | ive street and number) | | | 4b. 0 | City, Town, or I | Location of Deat | | | O 20 pama |
| | - LAGIIIII | Gilcrist Center | for Hospice | Care | | | Baltimo | are. | Ro | ltimo | 200 |
| - | Funeral | | | In yrs. last birthe | day) If Under 1 | Year If | Under 24 Hrs. | 8. Date of Bir (Month, Di | th Da | | lace (Stele or Foreign try) |
| | Director | 218-14-2585 | 1 @ M 2□F 77 | Yr | S. Months | Days 1 | lours Min. | (Month, Da | ay, Year) | | |
| | | Usuel Residence of Decedent | | | | | | Aug. Z | 1922 | wasni | ngton, D.C |
| | N S N | 10a. Stata 10b. County | 1 | Oc. City, Town o | or Location | | | | | 10 | Od. Inside City Limits |
| | r 28a-f show Indiffied at Irector | Maryland Howar | a | E11deat | + C:+ | | | | | | 1 ■ Yes 2 □ No |
| | the Ma 28e-f a notified | 10e. Street and Number | u | Ellicot | 10f. Zip (| Corde . | | | 10g. Citizen of V | What Coun | tru? |
| | 를 일찍 다 | | | | | | | | _ | | |
| | en and and and and and and and and and an | 9194 Twiford Cou | | | 2104 | | | | United | | |
| | her death ritems 23 siner.must | 11. Marital Status | 12. Wes Decedent Eve Armed Forces? | er in U,S. | Wes DecedeIf Yes, specific | nt of Hispa y Cuban, N | inic Origin? (S) Aexican, Puert | pecify Yes or No o Rican, etc.) | | e - Americ k, White, | |
| 20 | 4 24 F | | W Yes Give | | 1 Yes 2 | O No S | pecify: | | Specify | <i>r</i> : | |
| Maryland 21215-0020 | 72 hours after natural, or its fical Examina sted by Fu | | Yeer or Detes:19 | | | | | | | Whi | te |
| ry. | ed within 72 ho ygiena. Arr than "neturi It, the Medical.] Completed | 15. Decedent's (Specify only highest of | Education irade completed) | 16a. D | ecedent's Usual Give kind of work | Occupation done during | n na most of wor | kina | 16b. Kind of Bo | usiness/Ind | Justry |
| 2 | within sens. the Man | Elementery/Secondary (0-12) | College (1-4or 5+) | - '/ | Give kind of work ife. DO NOT use | retired) | | | | | |
| 2 | Manual Po | 12 | | Bu | ilder | | | | Const | ructi | on |
| P | SIES O | | st) | | | 18. | Mother's Nan | ne (First, Middle | , Maiden Surnam | 10) | |
| <u>a</u> | Mental arked a stic ev | | man | | | | Reheco | ca Bryan | | | |
| 5 | and N and N is man | 19a. Informent's Neme/Reletionship | | 19b. N | Aeiling Address | Street and | | | er, City or Town, | State. Zip | Code) |
| ž | | Cathorine B Cha | nman / Daught | | | | | | | | |
| | -456 | Catherine B. Cha | pman/ Daugnt | 20b. Place of D | isposition (Name | e of | urt, E | Dete | 20c. Location - | City of To | 4 Z |
| O | Pages nert of ret: if the rry or o | 1 Burial 2 ☐ Cremetion 3 | | cemetery, | crematory or oth | er place) | 1 | | | | |
| H | Part Part Part Part Part Part Part Part | 4 Donation 5 Other (Spec | 1 1 | Trinit | y Episc | opal | [] | L-30-00 | St. Mar | y's C | ity, MD |
| Baltimore, | Day of the state o | 21. Signature of Funeral Service Lic | ingen / | | 22. Neme end | Address of | Facility Br | insfiel | d Funer | al Ho | me, P.A. |
| 0 | 89799 | THE BOTTON | sfield, Jr. | M00052 | 22955 H | 11 xxx | ood Ros | d I eor | ardtown | MD | 20650-0279 |
| | | 23a. Part1. Enter the disease, or co | mplications that caused the | e deeth. Do no | enter the mode | of dying, s | uch es cardiac | or respiretory a | rrest. | , III | Approximate |
| 9 | Ohominian | shock, or heart teilure. List on | y one cause on each line. | | | | | | | | Interval Between Onset and Deeth |
| | Physician /Medical | Immediete Cause (Finel | 1 | | | | | | | - | |
| | Examiner | disease or condition resulting in deeth) | a | ung | CM | Cev | | | | 0 | months |
| | | | Du | e to (or es-a co | nsequence of): | | | | | | |
| - | P = 2 | | | | | | | | | 1 | |
| | assected in and tal-transit Examiner | Sequentially list conditions, if any, leeding to immediate | Du Du | e to (or es e co | nsequence of): | | | | | | 1 1 1 1 1 |
| ó | | | | | | | | | | i | |
| 68760, | eath certificate be asscuted attending physician and for use as the bunal-transit clar/Medical Examir | Cause (Disease or injury that initiated events resulting in death) Last | C. Du | e to (or es a cor | nsequence of): | | | | | - | |
| 89 | o ph as th | resulting in death) cast | | , | | | | | | i | |
| Box | attending pt for use as ti | | J d | | | | | | | <u> </u> | |
| m | death e atter od for u | Part II Other elgoificent conditions | anatelly stine to doubt but a | an annulate a ta al | | | - Death | Dan Die | tahaasa waa aa | ndelbude de | the course of death 9 |
| P.0 | | Part II. Other significant conditions | contributing to death but n | ior resound in n | ne underlying car | nse Giveri ii | i Pett I. | 1 | | | the cause of death? |
| | ed by the detach | | | | | | | 100 | Yaa 2□ No | 3 Prot | bably 4 Unknown |
| of Vital Records, | ines it | | | | | | | 04-144- | | 24h 18/ | va autonov tierlines |
| 0 | een sign hould be | | | | | | | | an autopsy ormed? | 8VB | are autopsy tindings allable prior to mpletion of cause |
| ec | 9 30 0 | | | | | | | | | | death? |
| Œ | The law require sate has been single 2 should Completed | | | | | | | 10 | Yes 2 No | 10 | Yas 2□ No |
| ta | ysician: The is certificate hadirector, page | 25. Was case referred to medical | | | | 26 | Place of Dea | ith (Check only | nnel | L | |
| > | Physician: this certific ral director, TO Be | examiner? 1 ☐ Yes 2 ☑ No | Hospitel: | 2 ☐ ER/Outp | atient 3 DO/ | Other | | lome 5 Resi | | (C | 11-000 |
| o | £ 5 8 | | 1 ☐ Inpatient 28a. Dete of Injury | 28b. Tirr | 415-6 | | → □ Moiswy n | | how injury occur | er (Specif) red | Hospie |
| Division | tal or Attanding P is after death. at Director: After to led in by the funera Certification; | 1 Netural 5 Pending investigati | (Month, Day Yo | ear) Inju | M M | c. Injury at Work? | 2 🗆 No | | , , , | | |
| S | death death ctor: / y the f | 2 Accident Investigati | be | A | | | 20160 | 204 Location | Cteant and Numb | as as Over | I Davida Mumbras |
| \geq | or Attance after death Director: | 4 ☐ Homicide determine | 28e. Place of Injury building, etc. (5 | - At nome, tarm Specify) | , street, tectory, | Office | | City or To | Street end Numb wn, Stete) | er or Hura | i Houte Number, |
| | A SES | | | | | | | | | | |
| | n 24 hour no Euner no Funer pletely fill bedical | | hysician: To the best of mainer: On the basis of ex | | | | | | | | |
| | | one) | and menner steted | 1. | | y opini | , 55601 0000 | und turio, | Time one piece, | | 00000(0) |
| | To T | 29b. Signature and title of pertition | 7 //1 | | 29c. | License nu | mber | | 29d. Date signe | d (Month, i | Day, Year) |
| | | XX mm | my lliky | | 16 | 125 | 205 | | JANU. | AVY | 27,2000 |
| | ~ | 30. Name and address of person who | completed cause of the | h (Itam 22a) (T- | me Print) | | | | | | |
| 1: | (۵ | MA R SAL | C R M C | / \\ \ / | N. CI | pula | c (7 | Bala | 4. Ma | 1 | (204 |
| | | 31. Date filed (Month, Day, Year) | 32. Registrer's | Signature | 17.00 | (1.7.00 | ١١رد | 470001 | 0. 7.(() | | |
| | State | FEB 0 1 20 | nn Dener | a 4 | do | 1 | | | | | |
| | Registrar | 0 1 20 | 00 | ~ | jajood | 101 | | | | | |

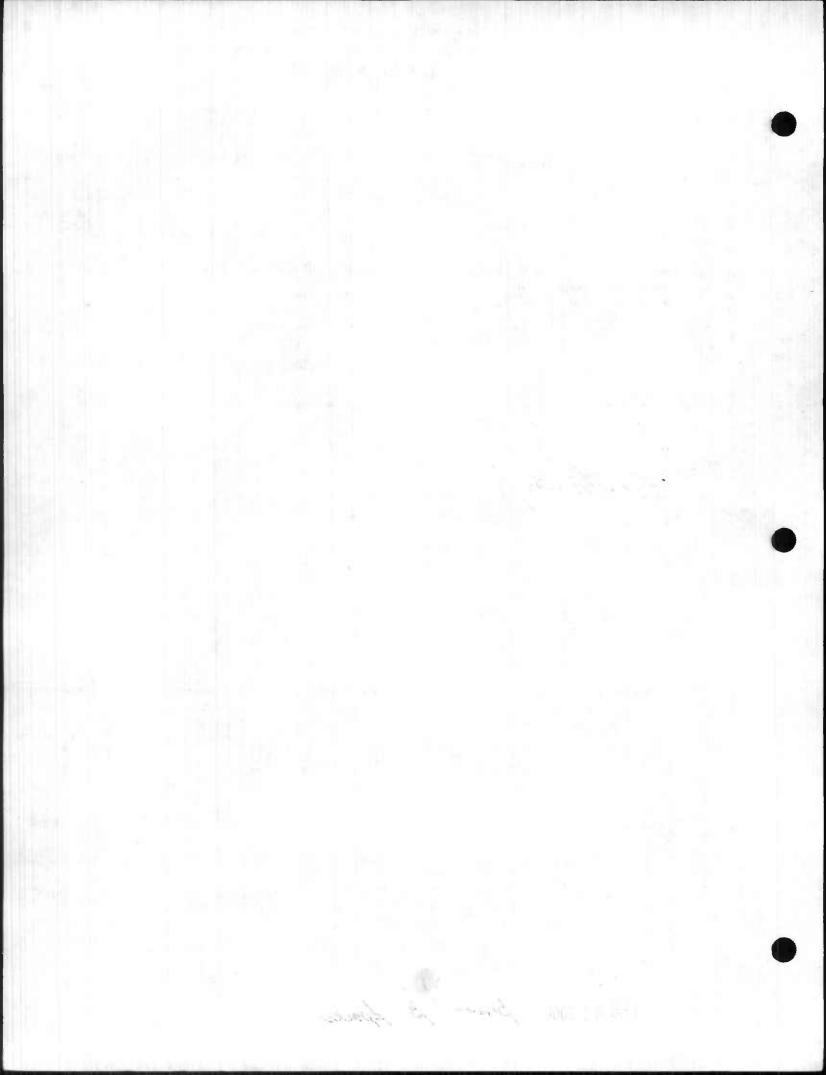
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Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

05066

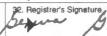
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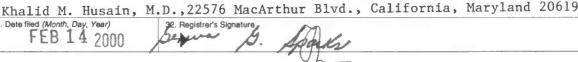


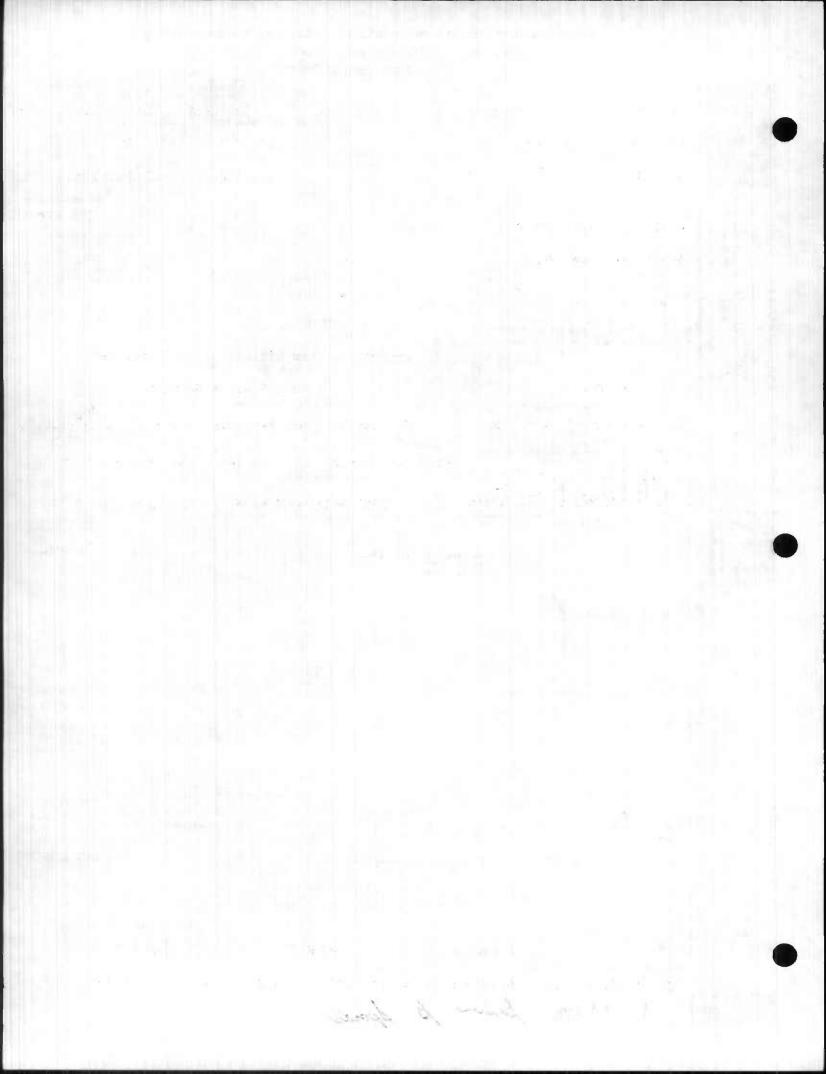
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 0 6 Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Russell Dominic 7, 2000 12:05 p.m. Corbin February /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 48539 Mattapany Road Mary's Lexington Park St. If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 ■ M 2 □ F Months Deys Hours Min. Yrs. Director 579-30-4579 Aug. 30,1928 | Maryland Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiena. Irriportant: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Modical Examinet must be notified at once. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 48539 Mattapany Road United States Funeral 20653 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bieck, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married 1 Nes 2 No I M Yes Zuno If Yes, Give Yeer or Detes:1956-75 1 ☐ Yes 2 No Specify: Specify. by 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 US Defense Noncommissioned Officer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Simon S. Corbin Edna Pauline Bennett 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code 20002 Dennis Edward Corbin / Son 1705 West Virginia Ave, N.E. Apt.#2, Washington, D.C. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ■ Buriei P □ Cremetion 3 □ Removal from State 5 Other (Specify) 4 Denetion St. Peter Claver 2-14-00 St. Inigoes, Maryland unerei Service License 22. Name and Address of Facility 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications/that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or near failure. List only one cause on each line. Approximete intervel Between Onset end Death **Physician** /Medical immediate Cause (Final 1 moust som Convor disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner physician end s the buriel-transit The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical thet initieted events resulting in deeth) Last Due to (or es e consequence of) 88 attending 980 o signed by the a 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Pres 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? should b 24e. Wes an autopsy performed? Completed s certificate has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director Be 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. injury et Work? After 1. Naturei 5 Pending 1 Yes 2 No n 24 hours efter death.

Ne Funerei Director: A pletaly filled in by the fu death. investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. within 2 To the To the 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifies 29c. License number D34535 2/11/00 i pun 350 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 31. Dete filed (Month, Day, Year) FEB 1 4 2000







Please Type or Print in Black indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death Reg. No. 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 29, MARY ELLEN CHENWORTH Jan. 2000 9:00 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2429 Baldwin Mill Road Upper Cross Roads Harford If Under 1 Year If Under 24 Hrs. 6. Data of Birth (Month, Days Hours Min. 8/25/1912 6. Sex 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) 1□ M 2XF 216-56-3719 87 Yrs. Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Upper Cross Roads (Fallston) Md. Harford 10e. Street and Number 10g. Citizan of What Country? 10f. Zlp Coda 2429 Baldwin Mill Road 21047 U.S.A. Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Marriad 1 Yas 2 No Specify: Caucasian þ 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Housewife Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Charles Keffer Walker Amy Melissa McCourtney 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda 21050 19a. Informant's Name/Ralationship (Type, Print) Lois E. Chenworth/Daughter 1622C Michelle Court Forest Hill, Md. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 2000 Bel Air, Maryland Air Mem. Gardens 22. Nama and Addrass of Facility E.G. Kurtz & Son Funeral Home, P.A. 23a Partt. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each life. Jarrettsville, Maryland Approximeta Interval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) 10 days Dua to (or as a consequence of): Examiner Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarfying Cause (Disaase or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Diabetes Mellitis þ 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy Completed 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa ratarrad to medicel axaminar? Be 26. Piaca of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 27. Mannar of Death 1 A Natural 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 D Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, tarm, streat, factory, office building, atc. (Specify) 4 Homlcida 29a. Certifiar 🖎 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated. Medical (Check only one) 2 Medical Examinar: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29b. Signatura and titla of portific 29d. Data signad (Month, Day, Year) January 31, 2000 P35012

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter deeth v Department of Heelth end Mental Hydiene. important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumstic event, the Medical Example mans once.

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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The lew requires that the death certificate be

altimore, Maryland 21215-0020

with the Maryland

State Registrar

31. Data tilad (Month, Day, Yaar)

FEB 1 2000

J. Kevin Lynch

30. Nama and address of parson who complated causa of death (Itam 23a) (Type, Print)

32. Registrar's Signatura Masse

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2 North Ave. BelAir, Ad. 21014.

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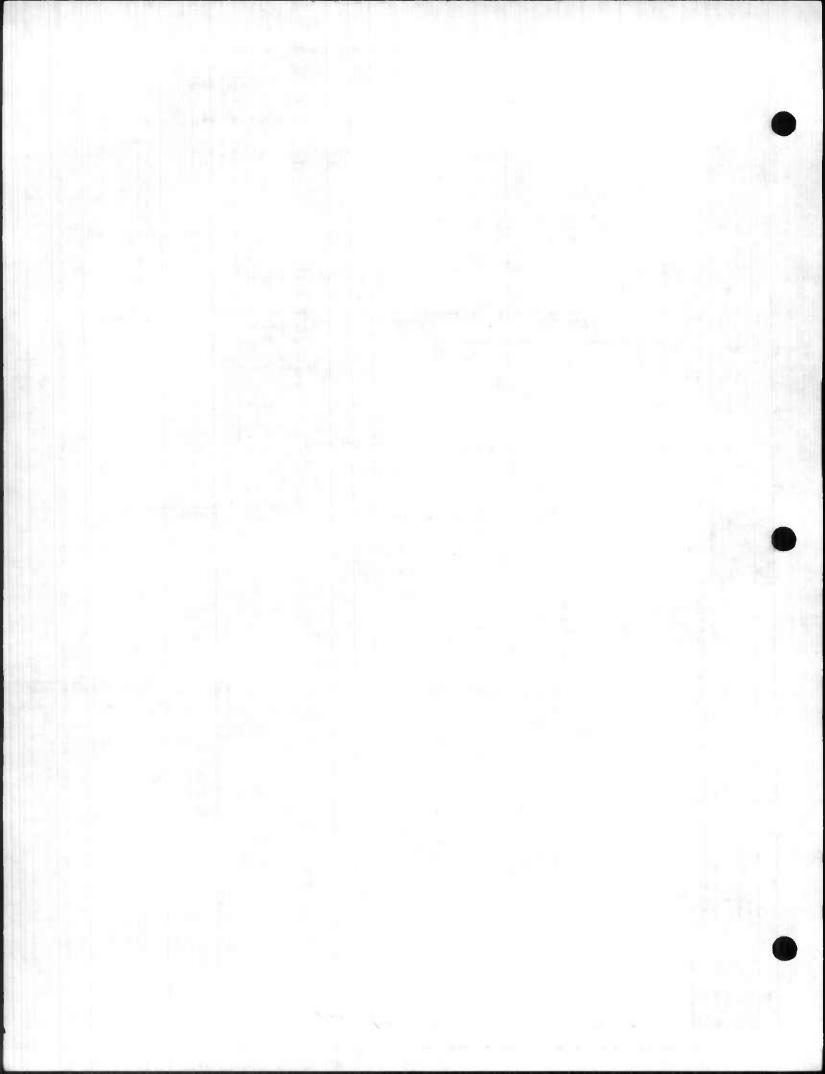
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Veni **Physician** 8:27P Roger Gayle Coffin 2000 24 January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Sept. 29,1956 North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours XXM 2□ F Months 215-80-3091 Director 43 Usuat Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or liams 23s or 28s-f show the Medical Examiner must be notified at Harford 1 Yes 2000 Director Edgewood 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1612 Meadowood Court 21040 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Disabled Dependent 0 17, Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 2 should be fi and Mental F Department of Health and Menta important: If Item 27 is marked Arlie Gayle Coffin Dorothey Ann Royal 19e. tnforment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy A. Kurnas (Sister) 1705 Carroll Avenue, Halethorpe, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Steta 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 1/29/00 Fallston, MD Highview Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Fuperal Service Licensee 22. Neme end Address of Facility Tarring-Cargo Funeral Home, P.A. mole 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine) tucks! disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical the th Due to (or as a consequence of): Box P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 20 NO 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 5 Panding investigation Neturel 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicat Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of continue 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edgewood, MD 21040 1308 31. Date filed (Month, Day, Year) 32/ Registrer's Signature State JAN 2 7 2000 Registrar

DHMH 16 Ray 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item 20b HCHD 1/27/200 Gertificate of Death brh 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** O/ -22 Catharine Smith Carson 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Death Examiner Mariner Health of Bel Air Bel Air Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5, 1908 If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1□M 201 Months Deys Hours 214-18-2762 91 Maryland Director Usual Rasidance of Decedan Pages 1 and 2 should be filed within 72 hours after death with the Maryland neet of Health and Mental Hyglene. ant: If itam 27 is marked other than "natural", or items 23s or 23s-f show ant: If itam 27 is marked other than "natural", or other traumatic evant, me Madeal Examiner must be notified at 10d. Insida City Limits 10e. Stata 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4409 Colt Lane 21078 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: 14. Rece - Amaricen Indian, 11. Maritai Stetus Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16e. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Professional Eiamantary/Secondary (0-12) Collega (1-4or 5+) Dry Cleaning Owner/Operator 17. Fathar's Name (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maidan Surnama) Be John Henry Bodt Matilda (u/k)Smith 19b. Meiling Address (Street and Number or Rural Routa Number, Clfy or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Robert J. Carson / Son 4409 Colt Lane, Havre de Grace, Maryland 21078 20b. Placa of Disposition (Nama of cematary, cramatory or other piece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial ⊋ ☐ Cramation Department of important: If any Injury or 5 [] Ott Paul's Lutheran Cem. 5-00 Aberdeen, Maryland 21. Signat 22. Nama and Addrass of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 realions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete interval Between Onsat and Death **Physician** Alzheimens /Medical immediata Cause (Finei 3 y 11ms disaesa or condition resulting in death) Examiner Due to (or es a consequenca of) Examiner physician and s the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequanca of) Physician/Medical Dua to (or as a consequanca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to deeth but not resulting in the underlying cause given in Part t. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings aveilable prior to completion of causa of daeth? Completed 24e. Was en eutopsy is certificate has director, page 2 2 No 1 Yas 2 No 1 Yas Be 25. Was casa rafarrad to medical 26. Placa of Daath (Check only ona) axaminar? Hospital: 1 Inpatiant Other: Nursing Home 5 Rasidanca 8 Other (Specify) 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 27, Mannar of Death 28b. Tima of After 1 Natural 5 Pending 2 No invastigation 2 Accidant

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

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To the Hospital or within 24 hours aft To the Funeral Dis completely filled in Medical 0

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29a. Cartifiar

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29b. Signeture end title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

29c. Licanse number

15 Certifying Phyeicien: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and mennar es stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year)

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Joott North 2000 32. Registrar's Signature

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28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

State Registrar

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Records,

Baltimore, Maryland

Division of Vital 8

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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Spevetz 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

Ginty Drive 3. Registrar's Signeture

N.E., Maryland

29c. License number

B0047631

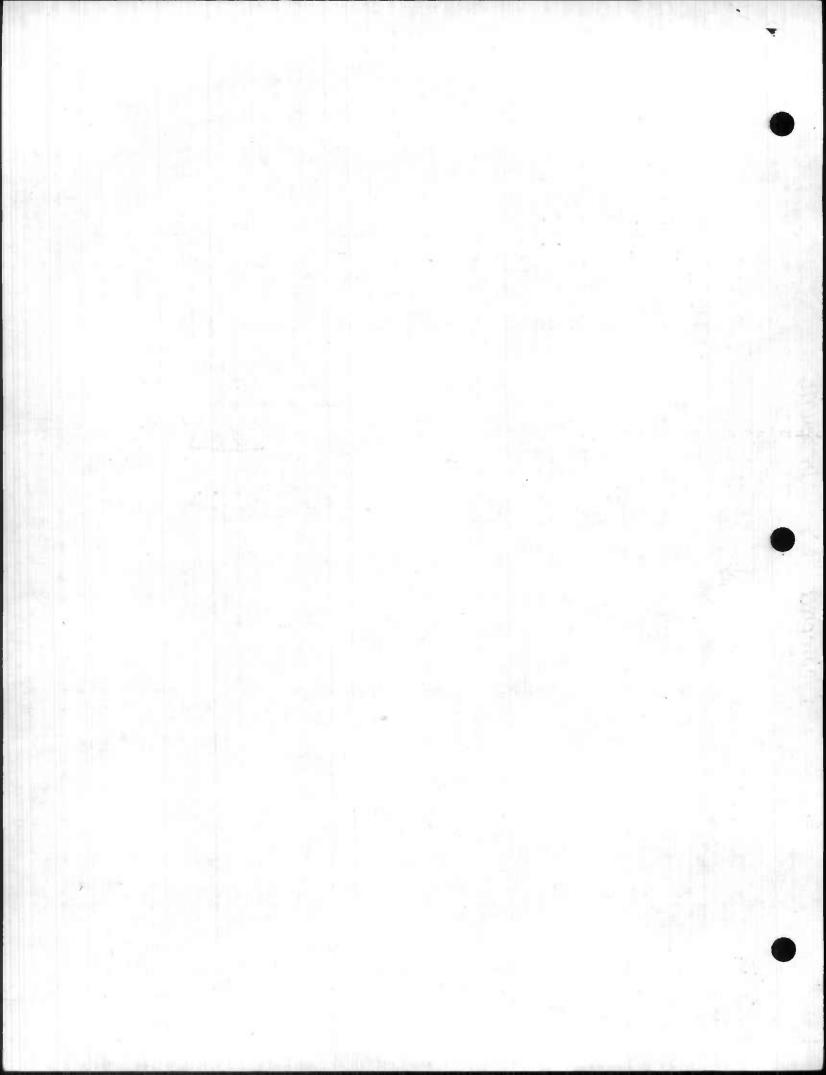
29d. Date signed (Month, Day, Year)

January 21, 2000

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Registrar DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** FRANCES 2000 6:50pm Covey February /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WILLIAM HILL HEALTH CARE EASTON TALBOT 8. Data of Birth (Month, Day, Year) If Under 1 Year | If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days 1 M 2 F Yes. 84 APRIL 1, 1915 MARYLAND 213-05-6270 Director Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Directo MD TALBOT EASTON 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda r than "natural", or items 23s or the Medical Examiner must be n 501 DUTCHMAN'S LANE 21601 USA Funeral 14. Race - American Indian, Black, White, atc. 12. Wes Decedant Ever in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) semit. Pages t and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If flem 27 is marked other than "ostural", or the 1 ☐ Yas 2 No If Yas, Give Year or Datas: 1 □ Naver Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE by 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentery/Secondary (0-12) Collega (1-4or 5+) APPAREL 11 -0-OFFICE MANAGER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) WILLIAM RAYMOND MARSHALL FLORENCE TARBUTTON 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) P.O. BOX 83, NEWCOMB, MD 21653 WILLIAM RAYMOND MARSHALL, III/NEPHEW 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from State CHESAPEAKE CREMATION CTR 8 2-2-00 CHESTER, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funaral Parvice Licensea 22. Nama end Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Part 1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or haart failura. List only ona causa on each line. Approximete Intervai Between Onset and Daath **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner physician and the buriel-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last Box 68760, certificate be Physician/Medical 88 use 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. the bed igned by the 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wera eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 20 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Was cesa rafarrad to madicel axaminar? 26. Piaca of Daath (Check only ona) Other: Nursing Homa 5 Residence 8 Other (Specify) To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Daath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of After Certification: 1. Natural 5 Panding after death. 1 Yas 2 No invastigation 2 Accidant 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 | HomicIda 24 hours a Hospital edical 29a. Cartifier Certifying Phyeician: To tha best of my knowledga, daath occurred at tha tima, data and place, end due to the ceuse(s) end manner as stated. (Check only one) 2 Madical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the ceuse(s) end manner stated. To the Within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certified 29c. Licansa number 30. Nama and addrass of person who completed cause of deeth (Itam 23e) (Type, Print) MICHAEL D. CROWLEY, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State FEB 0 3 2000 ▶

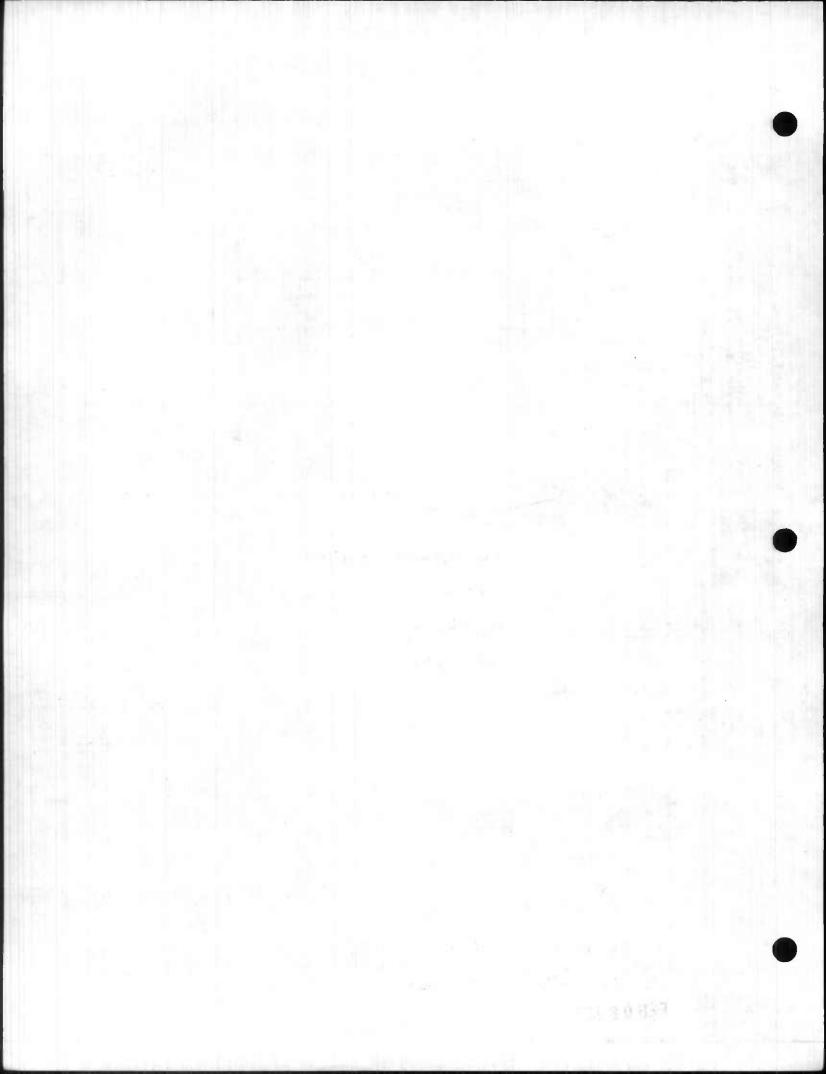
DHMH 16 Rev 6/95

Registrar

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| State of Maryland / Department of Health and Mental Hygiene | U | J |

| | | | Certificate | of Death | F | Reg. No. | |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| | 1. Decedent's Name (First, Middle, Las | 11) | | | 2. Date of Dea Month | Day | 3. Time of Death |
| ysician Medical | Junia Veda Corn | ell | | | Februar | y 7 2000 | 0156 |
| aminer | 4a Facility Name (If not institution, give | | | 4b. City, Town, or | Location of Death | 4c. County of | f Death |
| | Laurelwood Nurs | 0 | | Elkton | | Ceci | |
| eral ctor | 235-44-7515 | 7. Age (In yrs. 78 | Yrs. If Under 1 Months | Year If Under 24 Hr Days Hours Mir | | r, Year) 1921 W | 9. Birthplace (State or Foreig Country) lest Virginia |
| 3 . | Usual Residence of Decedent 10a. State 10b. County | 10c. Ci | ty, Town or Location | | | | 10d. Inside City Limit: |
| notifies | Maryland Cecil | No | orth East, | | | | 1 ☑ Yes 2 ☐ No |
| 2 5 | 10e. Street and Number 756 Bethel Church | Road | 10f. Zip C | | | 10g. Citizen of W | |
| traminer must by Funeral | 11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | | nt of Hispanic Origin? (Cuban, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | | - American Indian, , White, etc. |
| Completed b | 15. Decedent's Ed | | 16a. Decedent's Usuel (Give kind of work life. DO NOT use | Occupation | ortina | 16b. Kind of Bus | |
| ple | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NOT use | done during most of wi retired) | orking | | |
| LO LO | 6 | 001090 (1 401 01) | Homemak | er | | In he | r own home |
| Be C | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Ne | erne (First, Middle, | Maiden Sumeme |) |
| To | Russell | Jeffrey | | 1 | Lula | Je | ffrey |
| - | 19a. Informant's Name/Relationship (7 | | 19b. Mailing Address (| Street and Number or F | Rural Route Numbe | | |
| | Benjamin Goudy | | 197 Beave | r Trail, No | orth East | . Marvla | and 21901 |
| | 20a. Method of Disposition | 20b. I | Place of Disposition (Name | of | Date | | City or Town, State |
| | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Removal from State | cometery, cremetory or other th East Meth | odist Comet | Febru | ary | at Past |
| _ | 21. Signature a Edneral Service Licent | | | Address of Facility | ery 9,20 | UU NO1 | th East, |
| | 1/10/1/10 | | | | no 127 C | outh Mod | Maryland |
| | 23a. Part1. Enter the disease, or comp shock, or heart feiture. List only of | | North E | Funeral Hor | ne, 127 S | outh Mai | Approximate Interval Between |
| ledical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. COPD Due to (c Hyperte | or as a consequence of): or as a consequence of): or as a consequence of): | | | | |
| | L | d. COCOL | CVA | | | | 1 |
| / Physician/ | Part II. Other significant conditions co | ontributing to death but not res | sulting in the underlying cau | se given in Part I. | | | ribute to the cause of deat |
| | | | | | - 1 | | |
| pleted by | | | | | 24a. Was perfor | an autopsy med? | 24b. Were autopsy findings available prior to completion of cause of death? |
| Sompleted by | | | | | 24a. Was period | med? | available prior to completion of cause |
| Completed | 25. Was case referred to medical | | | 26. Place of D | perfo | med? | available prior to completion of cause of death? |
| o Be Completed | everniner? | Hospital: 1 ☐ Inpatient 2 ☐ | I ER/Outpatient 3 □ DOA | Other 10 | performance in the performance i | res 2 No | available prior to completion of cause of death? |
| To Be Completed | examiner? 1 Yes 2 TNo 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | | Other 10 | performance of the performance o | res 2 No | available prior to completion of cause of death? 1 Yes 2 No |
| To Be Completed | examiner? 1 Yes 2 TNo 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury M | Other: 4 Nursing Injury at Work? 1 Yes 2 No | performance perfor | red? Yes 2 No | available prior to completion of cause of death? 1 Yes 2 No |
| Certification: To Be Completed | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only) 2 Medical Exam | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Special Institute of the best of my known of the basis of examina | 28b. Tima of Injury M 28c ome, farm, street, factory, owledge, death occurred et | Other: 4 Nursing Injury at Work? 1 Yes 2 No | performance perfor | res 20 No re) lence 6 Othe now injury occurre Street and Numbe m, State) | available prior to completion of cause of death? 1 Yes 2 No r (Specify) id r or Rural Route Number, |
| edical Certification: To Be Completed | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29e. Certifier (Check only one) 1 Dertifying Phyone) | 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At h building, etc. (Special Projection of the Decision of the D | 28b. Tima of Injury M 28c ome, farm, street, factory, oveledge, death occurred et attion and/or investigation, in | Other: 4 Nursing I hipry at Work? I Yes 2 No Notifice the time, date and place my opinion, death occ | performance perfor | ree 2 No ne) lence 6 □Othe now injury occurre Street and Number m, State) cause(s) and mare date and placa, an | available prior to completion of cause of death? 1 Yes 2 No r (Specify) nd r or Rural Route Number, oner as stated. nd dua to the cause(s) |
| Certification: To Be Completed | examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Special Institute of the best of my known of the basis of examina | 28b. Tima of Injury M 28c ome, farm, street, factory, oveledge, death occurred et ation and/or investigation, in 29c. (| Other: 4 Nursing Injury at Work? 1 Yes 2 No | performance perfor | ree 2 No ne) lence 6 □Othe now injury occurre Street and Number m, State) cause(s) and mare date and placa, an | available prior to completion of cause of death? 1 Yes 2 No r (Specify) id |
| Medical Certification: To Be Completed | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier TU1 CHW HJ | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specialiner: On the basis of examine and manner stated. | 28b. Tima of Injury M ome, farm, street, factory, of the street, factory, of t | Other: 4 Nursing Injury at Work? 1 Yes 2 No office the time, date and place my opinion, death occulicense number | performance perfor | ree 2 No ne) lence 6 □Othe now injury occurre Street and Number m, State) cause(s) and mare date and placa, an | available prior to completion of cause of death? 1 Yes 2 No r (Specify) nd r or Rural Route Number, oner as stated. nd dua to the cause(s) |
| Medical Certification: To Be Comp | examiner? Yes 2 No | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specialiner: On the basis of examine and manner stated. | 28b. Tima of Injury M ome, farm, street, factory, oveledge, death occurred et ation and/or investigation, in 29c. I D0 n 23a) (Type, Print) | Other: 4 Nursing Injury at Work? 1 Yes 2 No office the time, date and place my opinion, death occulicense number | performance perfor | ree 2 No ne) lence 6 □Othe now injury occurre Street and Number m, State) cause(s) and mare date and placa, an | available prior to completion of cause of death? 1 Yes 2 No r (Specify) nd r or Rural Route Number, oner as stated. nd dua to the cause(s) |

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** ALAE CARMICAL JAN. 21 2000 2:30 pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL 511 PRINCE CHARLES AVENUE ODENTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2♥F Director 3 1907 ARKANSAS 239-36-6436 Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL ODENTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death v Funeral PRINCE CHARLES AVENUE 21113 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 20 If Yes, Give Yeer or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ARKANSAS BOARD OF Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Nem 27 is marked other tha any injury or other traumatic event, trail page. EDUCATION 12th TEACHER yrs. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be HENRY MARY WILLIAM HARRIS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) PRINCE CHARLES AVE. ODENTON, MD. LOVIE HENSON (DAUGHTER) 21113 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete PD Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 1/27/2000 LAUREL, MD. NAT. MEM. PARK 4 ☐ Donetion 5 ☐ Other (Specify) MD. 21. Signature of Funeral Servica Licensee 22. Neme end Address of Fecility WM. REESE & SONS MORTUARY, P.A. Larry & Keese 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 21401 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Cardiac arrest disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner oral inta The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, dementia Physician/Medical the Due to (or es a consequence of): signed by the all d be detached it Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown melleti Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Division of Vitai Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 Yes 2 XNo Be 26. Place of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel
2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 29e. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the 29c. License number 29b. Signeture and little of Certified 29d. Date signed (Month, Day, Year) Suite 107 Anna. Rd. Odenton, Wid 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) owski Janice 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State **JAN 28** Registrar

10 pourse p. sported

JAN 2 8 2000

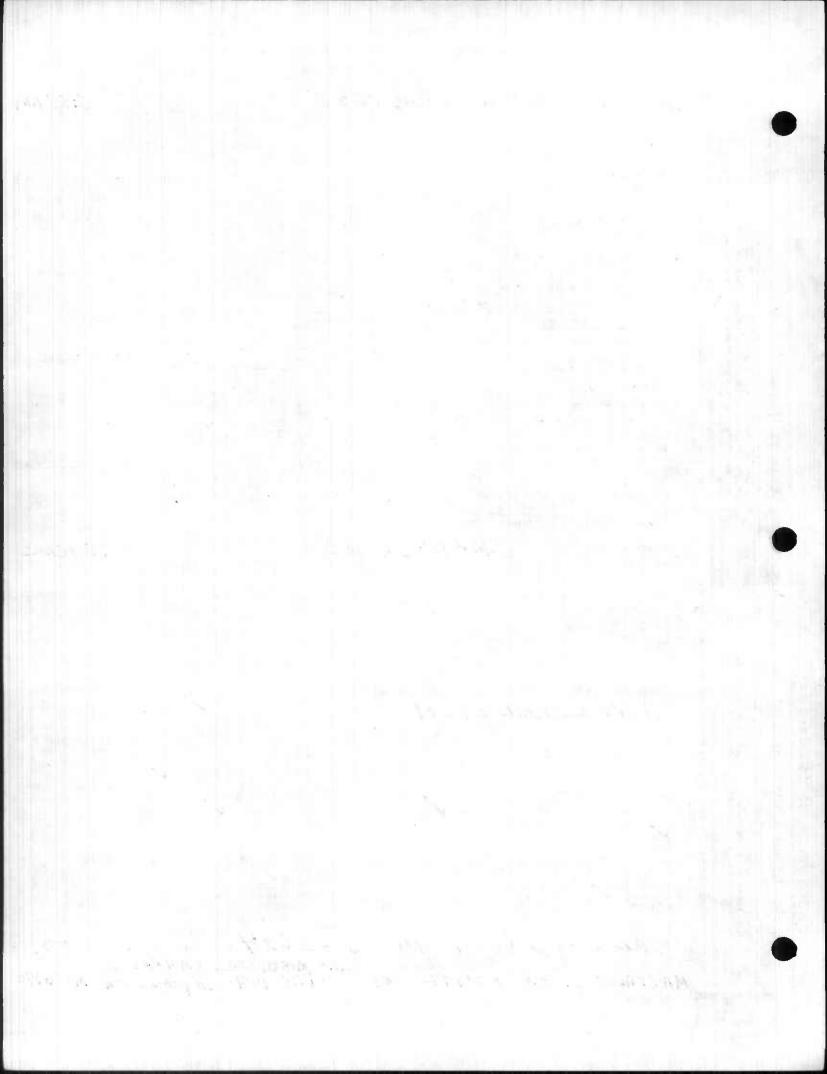
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death CRABTREE Day Month Year HAROLD **Physician** ERVIN 5:55 AN 30 JAN 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital
Social Security Number 6. Sex 7. Ag Hagerstown If Under 24 Hrs. | 8. D. Washington Birthplace (State or Foreign Country) If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months | Hours 10XM 2□ F Yrs 63 Jan 19 1937 Director 220-32-2777 Maryland Usual Residence of Decedent the Maryland 10s. State 10c. City. Town or Location 10b. County 10d. Inside City Limits pemit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mentel Hygiena. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other treumatic avent, the Medical Examinar must be notified as N Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 353 E. Franklin Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (XYes 2 () No If Yes, Give Year or Dates: Kore 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, atc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Korean Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Machinist Refrigeration Mfg 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Nama /First Middle, Last) 8 William W. Crabtree Margaret C. Gillam 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Mary Crabtree - Wife 353 E. Franklin Street Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2/3/2000 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** EMPHYSEMA /Medical Immediata Causa (Final 15 YEARS disease or condition rasulting in death) Examiner Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) 8 Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 1 Inpatient 2 IER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 2Bc. Injury at Work? 5 Pending investigation death. 1 Yes 2 No of Attend 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral C completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data end place, and due to the cause(s) and manner stated. edical (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier Masthew & Declary D53634 MD CAMPUS 11110 MEDICAL 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) BECKWITH MATTHEN G. SNITE 107 HAGERS TOWN MO 21740 MD 31. Data filed (Month, Day, Year) 32. Registrar's Signature FEB 03 2000 Registrar

CHABTREL

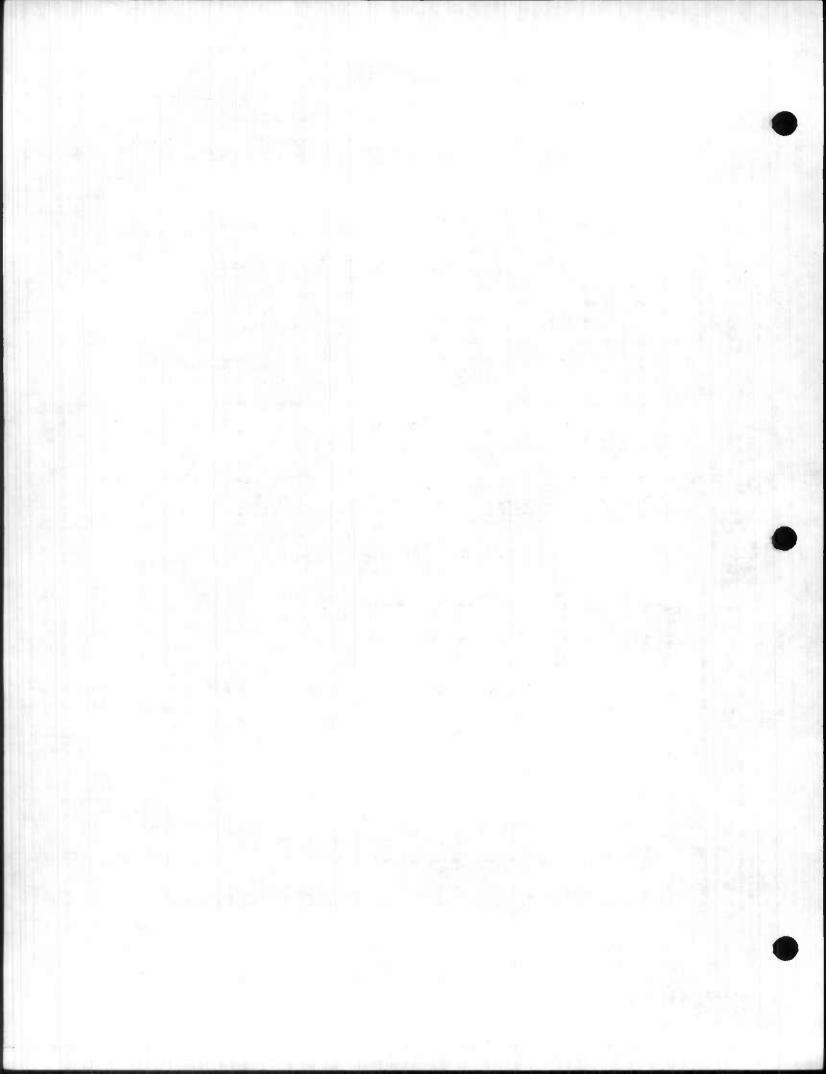
ARROLD ERUIN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 7 6

| | | | | | | Cen | tificate of | Death | | Reg. No. | | |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------|------------------------------------|-------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------|--------------------|--------------|----------------------------------------|
| • | D | 1. Decedent's Neme | (First, Middle, La | st) | | | | | 2. Date of I | | Vanz | 3. Time of Death |
| | Physician /Modical | | Josephin | e Mille | r (| Cox | | | Januar | ry 29,200 | O, ean | 12:05 PM |
| 11 | /Medical Examiner | 4a Facility Neme (If | not institution, giv | | | | | 4b. City, Town | , or Location of De | ath 4c. County | of Death | |
| | | Frederick | « Memoria | al Hospita | a1 | | | Freder | ick | Freder | rick | |
| - | Funeral | 5. Social Security Nu | mber 6. S | ex 7. A | ge (In yrs. la. | st birthday) | If Under 1 Year | If Under 24 | Hrs. 8. Date of E | | | ace (State or Foreign |
| ш | Director | 219-12-494 | 43 | □M 2X0F 7 | 5 | Yrs. | Months Days | Hours I | | 1,1924 | MD. | (7) |
| * | 9 | Usual Residence of D | | | | | | | That y | 1,125 | 110. | |
| - | Man . | 10a. Stete | 10b. County | | 10c. City, | Town or Loc | ation | | | | 10 | d. fnside City Limits |
| 1 | and the | WV | Grant | | Pete | rsburg | | | | | | 1 ☐ Yes 2 No |
| ě | or 25a-f s be notified | 10e. Street and Num | ber | | | | 10f. Zip Code | | | 10g. Citizen of 1 | What Count | y? |
| death with the Mandage | or here 23e or 25e-f sho imber must be notified at Fureraral Director | HC 32 Box | x 1054 | | | | 2684 | .7 | | USA | | |
| 1 | r Items 234 diner must | 11. Merital Stetus | 1001 | 12. Wes Deceden | t Ever in U,S | . 13. W | | | ? (Specify Yes or I | | e - America | |
| 0 | and a | 1 Never Marrie | d 2 Merried | 1 Yes 25 | | | and the same of th | | derio riicari, etc.) | | k, White, e | |
| 02 | 43 2 | | Divorced | Year or Detes | : | 1 | Yes 2 No | Specify: | | Specify | White | 2 |
| 5-0020 | or than 'natura' to the Medical. | (Specific | 15. Decedent's Ed y only highest gra | lucation | | 16a. Decede | ent's Usual Occup | ation | working | 16b. Kind of B | usiness/Indu | ustry |
| 2121 | - 54 | Elementery/Second | | College (1-4or | 5+) | life. D | O NOT use retired | d) | WOINING | | | |
| d 21 | Tage I | 11 | | | | Owner | /Manager | : | | Grocer | У | |
| Pu s | ETTE 6 | 17. Father's Neme (F | | D | 1.55 | | | | Name (First, Midd | | | |
| arylan | Ment when | Walter | G. | Ra | tliff | | | Hatti | e Mille | er Moble | ey . | |
| Maryland 21215-0020 | and Mental is marked o | 19e. Informent's Nam | me/Reletionship (| Type, Print) | | 19b. Meiling | Address (Street | and Number of | or Rural Route Nun | ber, City or Town, | State, Zip (| Code) |
| | er tr | Elizabeth | n Grubb | | | 10533 | Rocy Ric | lge Rd. | Rocky R | idge, Md. | 21778 | 3 |
| ore. | - 2 5 5 | 20a. Method of Dispo | | In | COL | ce of Dispos | ition (Name of etory or other place | ce) | Date | 20c. Location | City or Tov | vn, State |
| mor | The state of | | Other (Specific | Removet from State () | Mapl | e Hill | Cemeter | ТУ | 2/2/00 | Petersbu | irg,WV | 7. |
| altimore, | the part | 21. Signature of Fun | eral Service Licer | 500 | | 22. | Name end Addre | ss of Facility | Burner T | rado Sora | ricos | |
| m 8 | SEES | 0. | 10 F | 2 / | MBN | E 10 | 37 Dua1 | | gerstown | | | |
| | | 23a. Pert1. Enter the shock, or heert | e diseese, or com | plications that cause | 41.5.10.00 | | | | | | | Approximate |
| | hysician | shock, or heert | feilure. List only | one cause on each | line. | | | | | | | Intervel Between Onset and Death |
| | /Medical | Immediete Ceuse (F | | OVAR | 140) | Adel | 20 | | | | 1 / | Turing |
| E | xaminer | disease or condition resulting in death) | | e | | as e consequ | | | | | | 1 10001112 |
| | e e | | | | 000 10 (01 1 | as e consequ | ierice oij. | | | | 1 | |
| 200 | n and ial-transit | Sequentially list con- | ditions | b | Due to (or a | as a consequ | ence of): | | | | | |
| 0, | rial-tr | Sequentially list cond if any, teading to imm cause. Enter Undert | vina 📕 | | | , | | | | | - 1 | |
| ox 68760, | ding physician and se as the burial-transit | Cause (Disease or Inthat initiated events | | c | Due to (or a | is a consequ | ence of): | | | | + | |
| 68 | de po | resulting in death) La | 151 | | | | | | | | | |
| XO | esn. | | | d | | | | | | | - | |
| D. | d by the attendetached for u | Part II. Other signific | ant conditions of | ontributing to death | but not result | ing in the un | dertving cause giv | ren in Pert I. | 23b. D | d tobacco use co | ntribute to | the cause of death? |
| P.O | by the lacked | | | | | | | | 11 | Yes 25 No | 3 ☐ Prob | ably 4 Unknown |
| _ | bengis be de de | | | | | | | | _ | / | | |
| of Vital Records, | been signature s | | | | | | | | | s an autopsy | 24b. We | re autopsy findings ilable prior to |
| eco | 2 shoul | | | | | | | | _ pe | rlormed? | con | pletion of cause |
| I Re | | | | | | | | | 1,1 | Yes ZIANo | 10 | Yas ZENo |
| tal | certificate rector, pa | 25. Wes case referre | d to medical | | | | | 26 Place of | Deeth (Check onl | | | Tas Igano |
| of Vita | s certificadirector, | axaminer? | | Hospitel: | ient 2 🗆 El | R/Outpatient | 3 DOA Oth | vor- | ng Home 5□ Re | | er (Specify | 1 |
| | rthis eral d | 27. Menner of Death | | 28a. Dete of th | jury 2 | 8b. Time of | 28c, Injur | | | e how injury occur | | / |
| Division | th. After lune | 2 Accident | 5 Pending investigation | (Month, D | ay Year) | Injury | | k? Yes 2∐No | 1 314 | | | |
| /isi | after death Director: A d in by the i | 3 Suicide | 6 Could not be determined | 289. Piece of II | njury - At hom | e, ferm, stre | et, fectory, office | | | (Street and Numb | er or Rural | Route Number, |
| 0 8 | rs after death. al Director: After ted in by the luners Certification: | 4 Homicide | | building, e | tc. (Specify) | | | | City or 1 | own, State) | | |
| Hospital | | 29e. Certifier | Cortifying Ph | ysician: To the bes | t of my knowl | edge, death | occurred at the tir | ne, date and p | lace, and due to the | e cause(s) and ma | anner as sta | ited. |
| Đ. | n 24 hours | (Check only one) | Medical Exam | iner: On the besis and manner s | of examinetio teted. | n and/or inve | estigation, in my o | pinion, death o | occurred at the tim | e, date and place, | and due to | the cause(s) |
| To | To the | 29b. Signatura and th | tte of certifier | 26 0 | | | 29c. Licens | e number | | 29d Date, signe | 6 (Month, D | Day, Year) |
| | ., . | 1 / Au | 2019/1 | mound | | | D3 | 1761 | | 1/29 | 12.00 | 00 |
| | | 30. Name and address | ss of person who | completed cause of | death (Item 2 | 3a) (Tvna P | rint) | | | 1 | | |
| | | RUAN M | , D'Can | NOR MO | 501 | W, 80 | SVEUTH | 87, FR | ENERICK | MD 2 | 1701 | |
| | State | 31. Dete filed (Menth | Bey (Year) | NAR MD | trar's Signatu | re L | 1 | 1 | / / | | | |
| | Registrar | FE | D U I ZUI | JU / | | Ø. | spark. | 2 | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** January 30, 2000 0730 Dorothy Cross /Medical 4e. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year Months Days If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□ M 2₽F Days 81 Yrs. 216-12-4217 Director July 31,1918 Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner must be notified at 10d. Inaide City Limits Prince George's Brandywine Maryland Director 1 Yas 20 No 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 20613 12600 N. Keys Road Completed by Funeral 12. Was Decedent Evar in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yas, Giva
Yaar or Datas; Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritel Status 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury or other traumetic event, the Medical Examinat Black, White, atc 1 Navar Married 2 Married White 1 ☐ Yas 2 No Specify 3 N Widowed 4 Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Collage (1-4or 5+) N/A Elamantary/Secondary (0-12) Clerical State of Maryland 12th 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Ella Brady William S. Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Elm Drive West River Maryland 20778 19a. Informant's Name/Ralationship (Type, Print) Nancy Granahan (Daughter) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Feb. 3,2000 Clinton, Maryland Lee Funeral Home, Inc. 21. Signetura of Funaral Sarvice Licensas 22. Nama and Addrass of Fecility 6633 Old Alexandria Ferry Road Clinton, MD 20735 222 there 23a. Pert1. Entar tha diseesa, or complications that caused tha daeth. Do not antar tha mode of dying, auch as cardiec or raspiratory arrest, shock, or haart failura. List only one cause on eech lina. Approximate Interval Batween Onset and Death **Physician** Immedieta Cause (Final diseese or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner buriel-transit Sequantially ilst conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Disaase or Injury that initiated events resulting in daath) Lest Due to (or as a cons the 98 USB igned by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yas 21700 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 | Yas 2 | 1 | 16 1 Impatiant 2 ER/Outpatient 3□ DOA funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident in by the Could not be determined 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Cartifian t Certifying Physician: To tha best of my knowladge, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director; A

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

and

certificate

After this

or Attending Physicien:

with the Maryland

death

Baltimore, Maryland 21215-0020

State Registrar

M. 1911 31. Data filed (Month, Day, Year) FEB 0 1 2000

30. Nama and address of parson who complated cause of death (Itam 23a) (Type, Print)

29b. Signatura and titla of certifier

32, Registrer's Signature

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene \(\cap \)

| | | Certificate of Death | F | leg. No. | 3076 |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------|--------------------------------------------------------|
| | | Decedent's Name (First, Middle, Last) | 2. Date of Dea | th | 3. Tima of Death |
| | Physician | WILLIAM C. BELT SR. | JAN. 23 | 2000 Year | 0145 |
| | /Medical Examiner | 4e Facility Name (If not institution, give street and number) 4b. City, Town, or | r Location of Death | 4c. County of Deat | 1 |
| | | ANNE ARUNDEL MEDICAL CENTER ANNAPOL | TS | ANNE ARI | INDEL |
| | Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi | rs. 8. Dete of Birth | | hplece (State or Foreign untry) |
| | Director | 229-32-8604 Tel 70 Yrs. Months Days Hours Mill Usual Residence of Decedent | | | ARYLAND |
| | show dat | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | r 28a-f sh notified. | MARYLAND ANNE ARUNDEL ANNAPOLIS | | | 1) Yes 2□No |
| | or 28a-f a ba.notified Director | 10e. Street and Number 10f. Zip Code | 1 | 0g. Citizen of What Co | untry? |
| | | 18 PAROLE STREET 21401 | | USA | |
| | 8 25 2 | 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue | (Specify Yes or No- | 14. Race - Ame Black, White | |
| 21215-0020 | uraf, or ha al Examina of by Fur | 1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates: | orto ritoari, oto.) | Specify: BL | |
| 50 | ed within 72 ho ygiene. er then 'nehum 4, the Medical. Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w | and time | 16b. Kind of Business/ | ndustry |
| 21 | Man ald | (Specify only highest grade completed) (Give kind of work done during most of wife. DO NOT use retired) (Give kind of work done during most of wife. DO NOT use retired) | orking | R.C. HEI | RD & |
| 2 | d w d | 8th 0 LONGSHOREMAN | | COMPANY | |
| P | Be See Be | 17. Father's Name (First, Middle, Last) 18. Mother's N | ame (First, Middle, | Maiden Sumame) | |
| yla | Ment Ment affe | JOSEPH C. BELT SR. MARY | L. GREEN | ILEAF | |
| Maryland | 2 sho | 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Information 19b. Meiling Add | Rural Route Numbe | r, City or Town, State, 2 | lip Code) |
| | and and ar tr | WILLIAM C. BELT JR. (SON) 709 LEE STREET GL | EN BURNI | E, MD.210 | 061 |
| ore | 1 0 m m | 20a. Method of Disposition 1 | Date | 20c. Location - City or | |
| Ē | Pages ment of ant: If Its ury or o | 4 □ Donalion 5 □ Other (Specify) MT. TABOR CHURCH CEME | 1/29/2 | 2000 ANNA | POLIS, MD. |
| Baltimore | mit. | 21. Signature of Funeral Service Licensee 22. Name end Address of Facility | | | |
| ш | 207 5 8 | Lavy & Rees WM. REESE & SON | S MORTUA | ARY, P.A. | 21 |
| | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart leiture. List only one cause on each line. | ac or respiratory are | est, | Approximata Interval Batween |
| 3 | Physician | 1 | | | Onset and Death |
| 5 | /Medical | Immediate Cause (Final disease or condition Fld Fnc Carcinomy of /V | 19 | | 1 month |
| | Examiner | resulting in death) Due to (or as a consequence of): | | 1 | |
| Н | D # 5 | | • | | |
| | icate be executed physician and s the burial-transit adical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | |
| 68760, | ficate be execut 3 physician and ss the burlat-tran edical Exan | cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off: | | | |
| 87 | a se de D | that initiated events resulting in death) Last Due to (or as a consequence of): | | | |
| | 5 00 | d | | 1 | |
| Box | e attendir of for use | | | | |
| | of the death cert d by the attendin eteched for use. Physician/M | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | to the cause of death? |
| P.0 | | | 1 🗆 🖒 | 6 2 No 3 P | robebly 4 Unknown |
| Records, | een signe houid be d | | 24e. Was | an autopsy 24b. | Were autopsy findings |
| 00 | The law requin page 2 should Completed | | perfor | | available prior to completion of cause of death? |
| Re | 3 50 E | | 400 | 1/ | |
| ā | defan: The certificate h rector, page | | 1 U Y | | I ☐ Yes 2 ☐ No |
| Vital | | examiner? Hospital: Other: | eath (Check only or | | |
| o | Physical di | 1 LUmpatient 2 LEVOutpatient 3 LUOA 4 Nursing | | ence 6 Other (Specow injury occurred | orly) |
| O O | Afrecia funda | 1 Delatural 5 Pending (Month, Day Year) Injury Work? | | ,, | |
| 2 | Attending or deeth. ector: Afte fune fune liftcation | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, street, fectory, office | 28f. Location (S | treet and Number or Ru | ıral Route Number, |
| - | to a standing P as after death. It Director: After the funer and in by the funer Certification: | 4 ☐ Homicide building, efc. (Specify) | City or Tow | | |
| | To the Hospital or Attending Phywithin 24 hours skief death. To the Funeral Director: After this completely filled in by the funeral medical Certification: 7 | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pla | | | |
| | he Hospit in 24 hour he Funera pletsly fills | (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated. | curred at the time, o | ate and place, and dua | to the cause(s) |
| | To the Tour | 29b. Signature and title of certifier 29c. License number | 1 | 29d. Date signed (Mont | |
| | | 1 Junily 1000 038445 | | Jan 24 | ,2000 |
| | | 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) | 1 | | |
| | | ICO VICINSIEN 600 KINSPH MYE HOY | 14/0/10 | (10) | |
| | State Registrar | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | / | | |

100 James B. Junta

JAN 2 7 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Deta of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Catherine Bowden February 5, 0426 A 2000 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cecil Sunbridge Care Center If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. 91 161-16-3685 March 21, 1908 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 N Yes 2 No Director Maryland Cecil Charlestown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21914 United States 224 Conestoga Street Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indien, Bleck, White, etc. 11. Maritai Status 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Custom gasket maker Gasket manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If New 27 is marked o and Mental Laura Ginther 2 Andrew J. Moran 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 4601 Tyson Avenue, Philadelphia, PA Joseph F. Bowden/Son altimore, 20b. Piece of Disposition (Neme of 20c. Location - City or Town, Steta 20e. Method of Disposition Dete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Immaculate Conception Cemi 2/9/00 Cherry Hill, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 ra 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final UROSEPSIS DAYS diseese or condition resulting in deeth) Examiner Examiner sician and burlel-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical the th Due to (or as e consequence of): signed by the all d be detached for Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COLOSTONY PV 24b. Were eutopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Be · To Hospitet: 21 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. tnjury at Work? 5 Pending investigation 1 Netural deeth. 1 Yes 2 No 2 Accident or Attend after deeth Director: / 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner steted. within 2 To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signatura and titla of certifier M.O. 7,2000 D0047711 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) DAULO 6AK-BL MAULDIN Avanue NONTH EAST MAYYLAND 21901

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Mon

82. Registrar's Signeture

Carrier 3 - - - 4

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Dent prepad

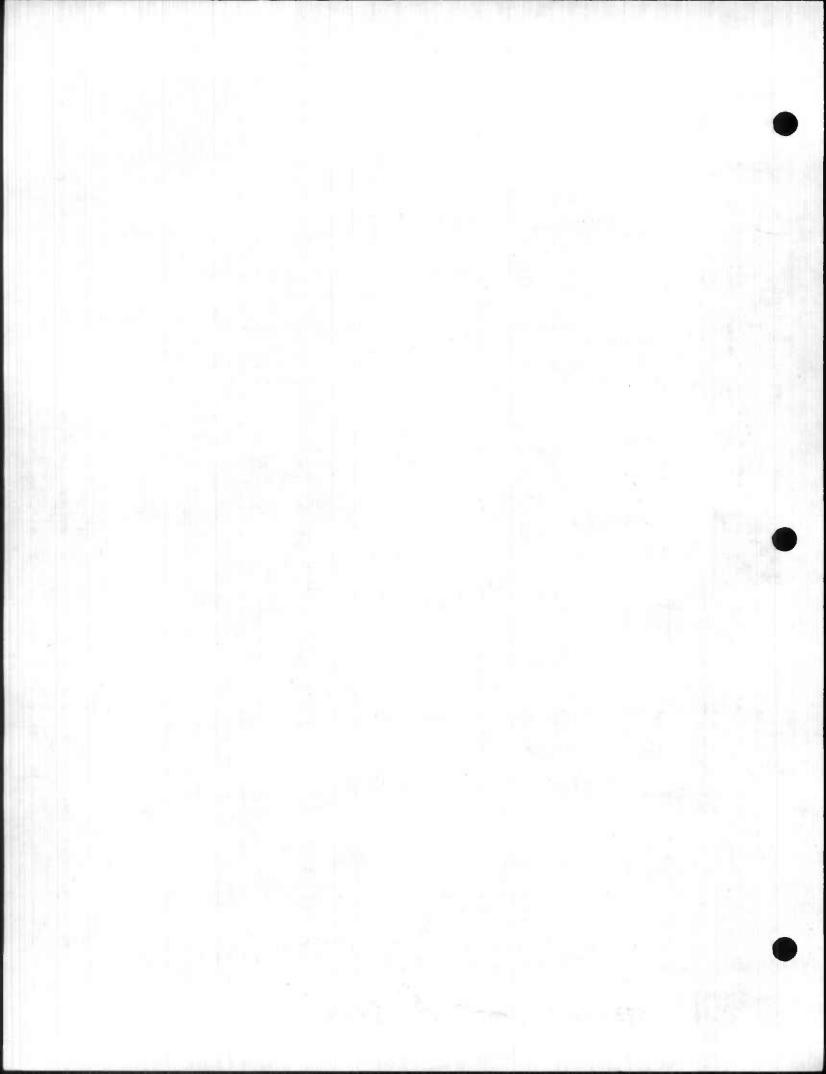
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Year Month **Physician ALEXANDER** ARTHUR DORSEY FEBRUARY 2,2000 /Medical 15:07 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. August 17,1915 9. Birthplace (State Country)
Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□ F 220 02 5150 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show. Nerte 23a or 28a-f sho ner must be notified at 1 ☐ Yes 2 No Directo Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 1313 Solomons Island Road 20678 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11 Merital Status 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married 'natural', or altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: ğ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) 12 Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental Important. If Item 27 is marked or Edith Victoria Johnson William Allen Dorsey 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Reletionship (Type, Print) 10th. Street, Wilmington, Delaware Anne Dorsey Hall / sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) St. Pauls Episcopal Cemetery 02/07/00 Prince Frederick, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory shock, or heart feiture. List only one cause on each line. 4405 Broomes Island Road, Port Republic, MD 20676
Lenter the mode of dying, such as cardiac or respiratory arrest,
Approximate
Interval Between
Onset and Death **Physician** /Medical Immediate Causa (Final MONTH disease or condition resulting in death) Examiner MONTH Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably Wunknown Renal failure à 24b. Were autopsy findings available prior to 24e. Wes an autopsy Be Completed Respiratory failure completion of cause of death? Congestive 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1\(\) Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No Pls B 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Adhar Natural 5 Pending 1 Yes 2 No investigation 2 Accident or Attand shar death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier eithin 24 h To the F (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 02-02-2000 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) DR. GYAN SURANA, MD MARYLAND DEALE, 20751 31. Date filed (Month, Dey, Year) 3 Registrar's Signature State FEB 0 9 2000

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygien U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 17, 2000 7:30 P.M. Edna Augusta Dixon January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Asbury-Solomons Solomons Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthpiace (State or Foreign Country) 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ■ M 2 ■ F Months Days Hours Min Yrs. 95 217-42-8693 **Director** June 18, 1904 Maryland Usual Residence of Decedent with the Marylend r 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ■ No Directo Maryland St. Mary's Mechanicsville 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23s or permit. Pages 1 and 2 should be filed within 72 hours efter deeth 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Wedicel Example traumatic event, the Wedicel Example traumatic United States 26839 South Sandgates Road 20659 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: þ 3 ₩Widowed 4 Divorced White Completed 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Stenographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Otto Sauer Emma Eliese Diener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 26803 South Sandgates Rd., Mechanicsville, MD 20659 Harry O. Dixon, Son 20b. Placa of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 1-21-00 Mechanicsville, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. den Edward N. Brinsfield, Jr.M00052 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. **Approximate** nterval Between Onset and Death Physician Immediate Cause (Final diseasa or condition resulting In death) /Medical fren monit Examiner Examiner physician and the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 88 USB 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 Ne 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 185 2010 or Attending Physician: 25. Was case ratarrad to medicat examiner? 26. Place of Daath (Check only one) 1 Yes 2 No Hospital: 1 □ Ampatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 0 this 28a. Data of Injury (Month, Dey Year) funerel Certification: 28c. Injury at (28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

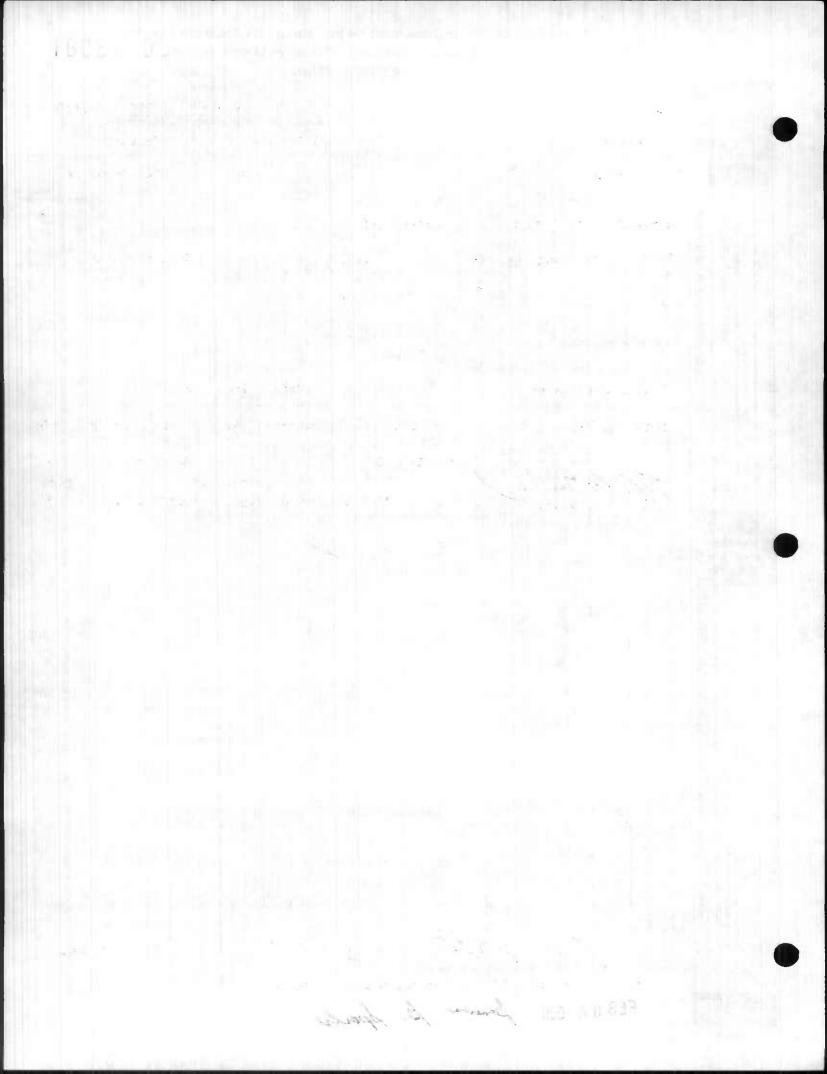
Funeral Director: A € □ Accident investigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida filled in Hospital 29a. Certifiar 1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, date and piace, and due to the causa(s) and mannar as stated. Medical tely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. vithin 2 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and titie of contilled 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Joseph John Barth III, Solomons, Maryland 20688

32. Registrar's Signature

Registrar

31. Date filed (Month Day, Year) FEB 0 8 2000



State of Maryland / Department of Health and Mental Hygiene 0 0 5082

| | | Certificate of Death | Reg. No. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------|
| | 1. Decedent's Name (First, Middle, Last) | | 2. Dete of Death | 3. Tima of Death |
| Physician (Modical | DENNIS KINS | EY DAUGHTON | Month Day January 25, | 2000 1300 |
| /Medical Examiner | 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or I | | unty of Death |
| | Fallston General Hospi | tal Fall | ston | Harford |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In) | rs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Birthplece (State or Foreign Country) |
| Director | 217-22-7979 10M 2DF 7 | Yrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 6/30/1926 | Maryland |
| with the Maryland a or 28a-f show be notified at | · | City, Town or Location | Air | t0d. Inside City Limits |
| vith the Marion of 28a-f a | 10e. Street and Number | 10f. Zip Code | | of What Country? |
| | | 21014 | | |
| fler death v r flems 23s | 11. Marital Status 12. Was Decedent Ever in | | pecify Yes or No- | U.S.A. Rece - American Indian, |
| har des | Armed Forces? 1 Never Married 2 Married 1 Yes 2 No | | o Rican, etc.) | Bleck, White, etc. |
| by by | 3 ☐ Widowed 4 ☐ Divorced | II 1□ Yes 2 No Specify: | Sp | ecity: Caucasian |
| 72 hours after death natural", or floms 23 | 15. Decedent's Education | 16a. Decedent's Usual Occupation | 16b. Kind (| of Business/Industry |
| | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give kind of work done during most of wor life. DO NOT use retired) | king | Electrical |
| Jene. | Elementary/Secondary (0-12) College (1-4or 5+) | Electrician | | Construction |
| | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, Maiden Sur | |
| | Charles Randolph | Daughton Lena | May | Daughton |
| d 2 should by and Menia by la marked by the unarked and un | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Ru | | |
| | Anna Lee Daughton /Wife | same as #10 a,b | .c.e.f | |
| I = 5 | | me de minimum de la companya del companya del companya de la compa | | ion - City or Town, Stete |
| 0 ± 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1 Burial 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify) | · | | ++arrilla MA |
| pemil. Pages 1 ar Department of Heal Important: if Item 2 any injury or other page. | 21. Signature of Funeral Service Licensee | 22 Name and Address of Facility | | ettsville, Md |
| E de la | 100 411 6KH | E.G. Kurtz & | | Home, P.A. |
| | 11. Studeter Jung | Jarrettsville | , Maryland | |
| | 23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. | eath. Do not enter the mode of dying, such as cardiac | or respiratory errest, | Approximete Intervel Between |
| Physician | | | | Onset and Deeth |
| / /Medical Examiner | Immediate Cause (Final disease or condition Hy Perco | apnic Respiratory | Jailyre | 4-4%. |
| | resulting in death) Due t | o (or as a consequence of): | | |
| IR & S | - Emphy | sema o (or as a consequence of): | | 10 4% - |
| fleate be assected fleate be assected to physician and the burist-transit and the burist-tr | Sequentially list conditions, Due to | o (or as a consequence of): | | |
| oof ou, and illicate be executed by physician and as the buriel-transference and | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | fibrillation | | 3 47. |
| the | resulting in death) Last | o (or as a consequence of): | | |
| 2 5 2 | L. Hypo xau | emig. | | |
| Clary | a. 1. [155] | • | | |
| . 0 . 0 | Part II. Other significant conditions contributing to death but not | resulting in the underlying cause given in Part I. | 23b. Did tobacco usa | a contributa to the causa of deat! |
| ed by th | Cor-pulmonalae | | 1) Yea 201 | No 3 Probably 4 Unknow |
| be de d | FAINTONATION | | /- | |
| a law requires to the bear of the bear signed by th | Pulmonary Hyperten | sign | 24a. Wes an autopsy performed? | 24b. Were autopsy lindings available prior to |
| law ra | Tall Tall Tall | | | completion of cause of death? |
| The lay | Asbestusis. Puly | nonary Fibrosis | 1 Yes 2 € | t Yes 2 No |
| cartificata inector, pag | 25. Was case referred to medical | | eth (Check only one) | /- |
| Physiolan: this cartific ral director, | examiner? 1 Ves 2 Vo Hospital: 1 Inpetient 2 | Other | lome 5 ☐ Residence 6 ☐ | Other (Specify) |
| Physical of the Transfer of Tr | 27. Manner of Death 28s. Cate of Injury | | 28d. Describe how injury or | |
| al or Attanding P re shart death. al Director: Attart led in by the funeri | Naturat 5 Pending (Month, Day Year | Injury Work? M 1 Yes 2 No | | |
| Attand death ctor: / y the f | 3 Suicide 6 Could not be 28e. Place of Injury - A | t home, lerm, street, factory, office | 28f. Location (Street end N | lumber or Rural Route Number, |
| Paris I | 4 Homicide building, etc. (Sp. | ecify) | City or Town, Stete) | |
| and and o | 29a. Certifier 1 Certifying Physicians: To the best of my | knowledge, death occurred at the time, date end place | and due to the cause(s) an | d menner as stated |
| To the Hospital or Attant Within 24 hours after deal to the Funeral Director: completally filled in by the Medical Certifical | | ination and/or investigation, in my opinion, deeth occu | rred et the time, date end pla | ace, and dua to the cause(s) |
| Me appear | 29b. Signature and title of certifier | 29c. License number | 29d. Date s | igned (Month, Day, Year) |
| 0=0^ - | | | | |
| F 1 2 2 2 | * Kostono | | | - 26 - 00 |
| LATES - | Brign | | 1 JAN | -25-00 |
| | 30. Name and address of person who completed cause of death (| | | |
| 7 | B. Parekh mp. 1908 | HARFORD ROAD, F | | |
| State Registrar | 30. Name and address of person who completed cause of death (B. Payekh MD. 1908) 31. Date filed (Month, Day, Year) JAN 28 2000 | HARFORD ROAD, F | | -25-00 .MD.21047. |

DHMH 16 Rev 6/95

THE CHARGEST STREET . 10 -The transfer of which · WY Huge your life. Los spalmenarace. the Mary to Authorize daine of the state of the second the control of the d B. Breisel, ep. 1924 parties West, recourse in calebra.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year DAVIS Jan **EDITH** IONA 2,000 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Bel Air Bel Air Harford If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthdev) 8. Dale of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 10 M XXF Hours Months Deys 79 213-46-1658 Sept. 1, 1920 New York Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Churchville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 513 Calvary Road, P.O. Box 86 21028 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes ♣ ♣ No If Yes, Give Year or Deles: 14. Race - American Indien Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 Tes 2 No Specify: Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Oluf Jensen Mimmi (nmn) (U/K) (nmn) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sarah D. Cassilly - Daughter 513 Calvary Rd., P.O. Box 86, Churchville, MD 21028 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/00 Hilltop Service Corp. Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) chs bucher Pulmonay Dileare Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown secondary to intracronial 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical **Examiner**

Department o important: If any injury or

Physician

/Medical

Examiner

10a. Stale

Funeral

Director

must be notified at

r than "natural", or items the Medical Examiner in

nit. Pages 1 and 2 should be filed within 72 hours effer carment of Health and Mentel thygiene. ortant: If fem 27 is marked other than "natural", or flee injury or other traumate event, pre Region Examina

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

deeth with the Maryland

physician and s the buriel-transit 80 950 signed l

Examiner page 2 s certificate Be P. After this funeral

29a. Certifier (Check only one)

Physician/Medical Completed by

requires that the deeth certificets be executed efter death. Director: Aft 24 hours e

Edith Lhuis Division of Vital Records, P.O. Box 68760,

State Registrar

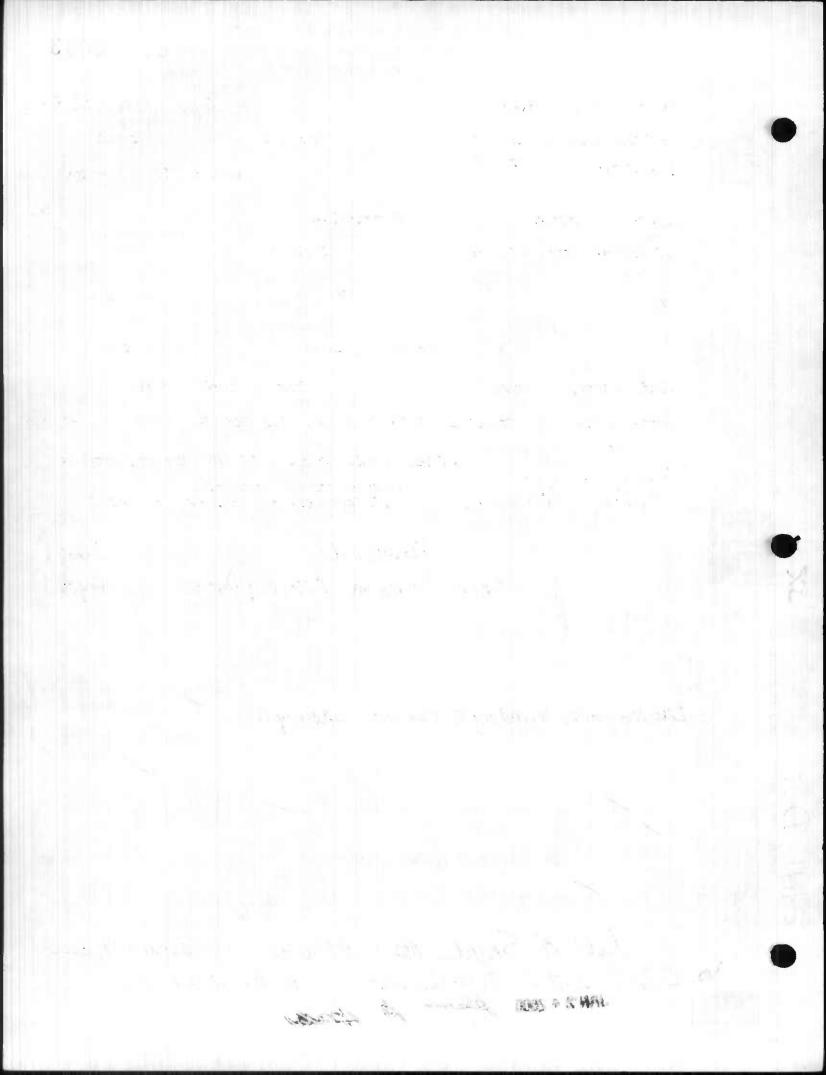
Medical

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 20 No 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - Al home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and little of cartifier

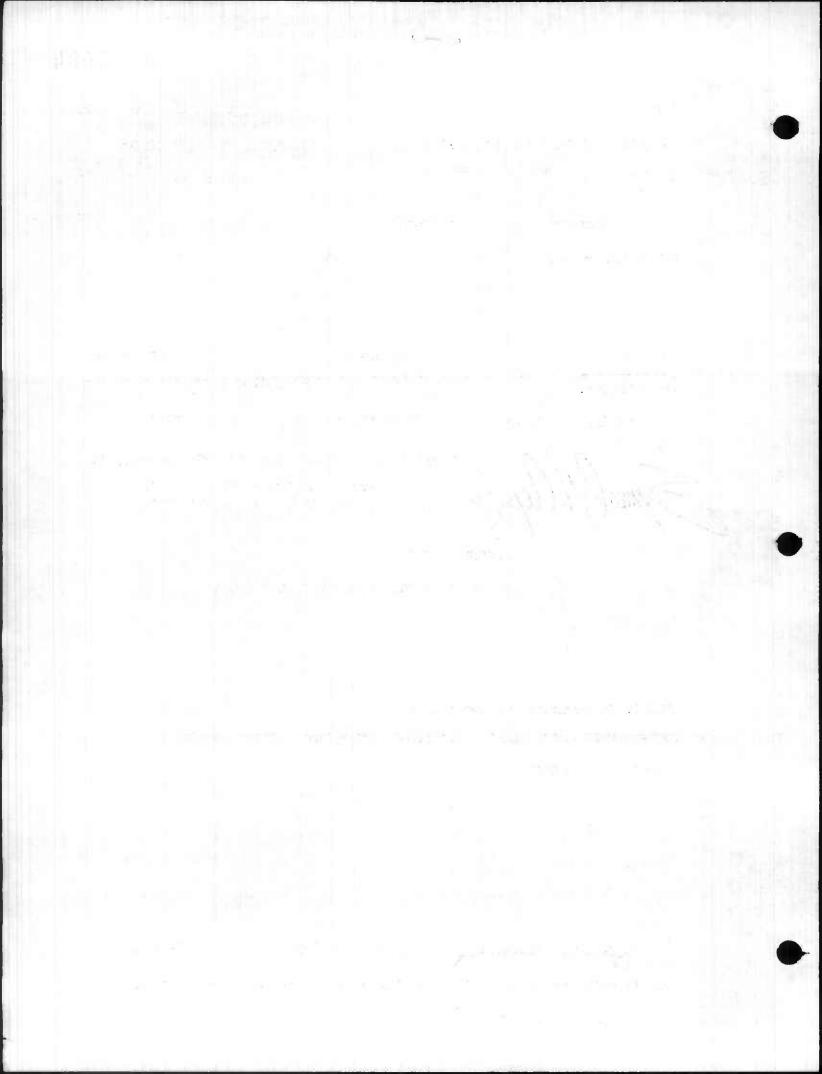
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within 24 ho To the Fune completely fi



State of Maryland / Department of Health and Mental Hygien 0 0508

| _ | | | 1 Decedentis Name (Fi | | | , , , , , | Ce | ertificate of | Death | | Reg. No. | U | 0084 |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------|----------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------|-----------------------------------------|--------------------------|--------------------------------------------------|
| п | Physic | ian | Decedent's Name (Fire JAMES DUFF | | 5() | | | | | 2. Date of De | Dey | Year | 3. Time of Death |
| ч | /Medi | | 4e. Facility Name (If not | | a etraat and num | has) | | | 4b. City, Town, or | Location of Deep | 29 0 | - | 2214 |
| | Examir | ner | | | | | nno. | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| Н | Funeval | | PENINSULA F 5. Social Security Number | | - ^- | . Age (In yrs. | | () If Under 1 Yea | SALISBU r If Under 24 Hrs | | WICOM | | laco (Stata or Eomiga |
| | Funerai Director | | 230-60-750 Usual Residence of Deci | 9 1 | XM 2□F | 55 | Yrs. | Months Day | s Hours Min | . (Month, Da | iy, Year) 44 | Coun | lace (Stata or Foreign try) VA |
| | death with the Maryland rms 23a or 28a-f show | | | County | | 10c. Cit | y, Town or I | ocation | | | | 1 | Od. Inside City Limits |
| | Mar Mar | to | VA A | ccomacl | c | Ac | comac | | | | | | 1 X Yes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | | | | 10f. Zip Code | | | 10g. Citizen of V | Whaf Coun | try? |
| | th wil | | 25126 Upsh | ur Lane | 9 | | | 2330 | 01 | | USA | | |
| 20 | s 1 end 2 should be filed within 72 hours efter death with the Marylan I Health and Mental Hygiene. If Health and Mental Hygiene. It is marked other than "natural", or farms 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at | by Funeral | 11. Maritel Status Never Married | 2 Merried | 12. Wes Deced Armed Ford 1 Yes 2 If Yes, Give | es? No | ,S. 13 | . Was Decedent of If Yes, specify Cu | Hispenic Orlgin? (Sban, Mexican, Puer | Specify Yes or No to Rican, etc.) | 14. Rec Blac Specify | a - Americ ck, White, | etc. |
| 21215-0020 | hour hural | | 3 Widowed 4 1 | | Year or Dat | es: | 10. 0 | dealer the close | | | | pra | |
| 15 | in 72 nan 'n | Completed | (Specify or | Decedent's Ed | da complated) | | /Giv | edent's Usual Occi e kind of work don DO NOT use retir | e during most of wa | rking | 18b. Kind of Bu | isiness/ind | lustry |
| 212 | yene. | E | Elementary/Secondary 9th | (0-12) | College (1-4 | lor 5+) | Me | chanic | | | Auto | motiv | re. |
| b | e filed al Hygie other vent, n | BeC | 17. Father's Name (First, | Middla, Last) | | | | | 18. Mother's Na | me (First, Middla | | | |
| Maryland | should be ind Mental marked or umstic eve | ToB | James Daug | htry | | | | | Elizab | eth Duff | y | | |
| an | 2 sho and h is ma | | 19a. Informant's Name/F | Relationship (7 | ype, Print) | | 19b. Mal | ling Address (Street | at and Number or R | ural Route Numb | er, City or Town, | Stete, Zip | Coda) |
| Σ | Health a Health a sem 27 is | | Mary Washi | ngton/S | Sister | | 252 | 54 Church | Road, O | nley, VA | 23418 | | |
| Baltimore, | of Hein | | 20a. Method of Disposition | | | 20b. P | lace of Disp | osition (Nama of amatory or other pi | aca) | Date | 20c. Location - | City or To | wn, State |
| Ĕ | permit. Pages Department of Important: If Re any injury or o | | 1 XBurial 2 Cre 4 Donation 5 D | | | are | | | Cemeter | y 2/5/00 | Accom | ac. V | 'A |
| ä | Departi Departi Importa any Inji 2008 | < | eT. Signature of Funeral | Service Ligary | 60/ | 1 | 2 | 2. Name end Add | ess of Facility | | | | |
| 8 | 89E88 | | NIMIN | //// | DON. | de | | | HUMBLES | | | | |
| | 1 | | 281. Pagf. Enter the dis shock, or heart fails | egne-or comp | fications that out | sed the deat | h. Do not er | nter the mode of dy | 176, Ac | comac, v | rest, | | Approximate |
| а | Physician | | 7 | go, cast only t | 7 | at mie. | | | | | | | Interval Between Onset and Death |
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| | Examiner | L | resulting in death) | | | | | equence of): | | | | - // | |
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| | ate be executed hysician and the butal-transit | Examiner | Sequentielly list condition if any, leading to immedicause. Enter Underlying | ns, | | Due to (o | r es a conse | quence of): | | | | 1 | |
| 68760, | eath certificate be accountable and attending physician and for use as the bunal-train | | Cause (Disease or injury | 7 | C | | | | | | | | |
| 387 | cata phys s the | edical | that initieted events resulting in death) Lest | | | Due to (o | r as a conse | quence of): | | | | | |
| ox | ding ding | ΣI | | | d | | | | | | | | |
| ă | death e atter of for u | clar | | | | | | | | | | | |
| o | y th | Physician/ | Part If. Other significant | | | | | | iven in Part I. | | | | the cause of death? |
| S, D | the de | by PI | CHRONIC OB | SRTUCT | LVE PULM | ONARY | DISEA | SE | | 10 | Yes 2 No | 3 Prob | ably 4 Unknown |
| rds | requires l | | POST-PNEUM | ONECTO | MY, LEFT | , CARC | INOMA | 6 YEARS | AGO. | 24e. Was | an autopsy | 24b. We | re autopsy findings |
| Record | > LI (r) | Completed | | | | | | | | perfo | med? | con | allable prior to appletion of cause deeth? |
| | 0 - 0 | mo | ASTHMATIC | BRONCH | ITIS | | | | | 10 | Van 0 1901a | - | Yes 2□ No |
| Vita | ician: The certificate rector, pag | BeC | 25. Wes case referred to | medical | | | | | 26 Place of De | eth (Check only o | Yes 2 No | | TYES ZUNO |
| \geq | ysician: is certifica director, | ToB | examiner? 1 ☑ Yes 2 ☐ No | | Hospitel: | nationt X | FR/Outnatie | nt 3 DOA O | ther: 4 Nursing h | | | ar (Specifi | d |
| וסר | 문 문들 | | 27. Menner of Death | | 28e. Dete of | | 28b. Time o | | | | now Injury occurr | | / |
| 0 | tending Phieath. | atic | 1 X Neturel 5 ☐ 2 ☐ Accident | Pending Investigation | (IVOTILI), | Day roary | ii ijui y | | Yes 2 No | | | | |
| Division | | Certification: | 3 ☐ Suicide 6 ☐ 4 ☐ Homlcide | Could not be determined | 286. PIECE 01 | Injury - At ho | me, farm, s | reet, factory, office | | 28f. Location (: City or Tox | Street end Numb | er or Rural | Routa Number, |
| | is efter or all Direction | Cer | | | | , (| , | | | | , 5.6.7 | | |
| | To the Hospital within 24 hours et oute Funeral Completely filled | edical | 29a. Certifier 1 (Check only one) | Cartifying Phy Medical Exami | alcfan: To the be iner: On the basi and manner | s of exemine | wledge, dea ion and/or Ir | th occurred at the to execute the total the to | ime, date and place opinion, death occu | red at the time, | ceuse(s) and me dete end placa, a | nner as stand due to | ated. the ceuse(s) |
| | To the comple | Ž | 29b. Signature and title o | f cartifier | | | | 29c. Licen | se number | | 29d. Dete signed | (Month, L | Day, Year) |
| | , | | Cas | -56 | Buller | Qu. | I | DOC DOC | 03599 | | 1-30-0 | 00 | |
| | 1 | | 30. Name and eddress of | person who o | ompleted cause | of deeth (Item | 23a) (Type | , Print) | | | | • | |
| | | | JOHN T. BU | LKELEY | M.D. | 106 | MILFO | RD STREET | SALIS | BURY, MD | . 21804 | 1 | |
| | Sta | | 31. Date filed (Month, Da | | | istrar's Signa | | / | | | | | |
| | Registr | ar | FEI | B 0 8 21 | JUU A | Trans | No. | Bjoon. | 2 | | | | |



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last)

Physician /Medical Examiner

Directo

Funeral

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Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

edical

JESSE M.T. DAVIS

Month JANUARY

28,

3 Time of Death

4a Facility Nama (If not institution, give street and number)

4b. City, Town, or Location of Death

2000 6:33AM 4c. County of Death

Funeral

P.G. HOSPITAL 5. Social Security Number 7. Aga (In yrs. last birthday) 1 M 2 ☐ F 77 Yrs. 116-22-8698

CHEVERLY If Under 1 Year If Undar 24 Hrs. Days

PRINCE GEORGE'S Birthplaca (Stata or Foraign Country)

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiena. If important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any Injury or other treumstic event, the Medical Examinating the market enconcern.

Physician

/Medical Examiner

physician and the burial-transit

80 980

ed by the a

been si

certificata has b

• Hospital or Attending Physician: 24 hours aftar death.
• Funeral Director: After this certifical eleity filled in by the funeral director.

To the Hosp within 24 hos To the Fune completely fi

The law requires that the death certificate be assecuted

Division of Vital Records, P.O. Box 68760,

Usual Basidence of Decedant 10a. Stata 10b. County Maryland Prince George's

10c. City, Town or Location

Seat Pleasant

10d. insida City Limits

DEC. 21, 1922 Long Island, NY

10e. Street and Number

10f Zin Coda

1 ☐ Yas 2 XNo

N☐ Yas 2 ☐ No 10g. Citizen of What Country?

524- 69th ST. 11. Marital Status

12. Was Dacedent Evar in U,S. Armed Forcas?

20743 Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) Specify:

14. Bace - American Indian. Biack, Whita, atc. WHITE

1 ☐ Navar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

1 NYas 2 No ARMY If Yes, Giva Yaar or Datas 1940-1946

Collega (1-4or 5+)

16b Kind of Business/Industry

USA

15. Decedant's Education (Spacify only highast grada complated) Elemantary/Secondary (0-12)

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) CARPENTER

PVT.

11th

17. Fathar's Nama (First, Middla, Last) ALBERT B.C. DAVIS 18. Mothar's Nama (First, Middle, Maidan Sumama)

ALICE SLITER

19a. Informant's Name/Ralationship (Type, Print)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 524- 69th ST.

VERONICA DAVIS/ WIFE

20a. Mathod of Disposition 1 ☐ Burial 2 🕅 Cramation 3 ☐ Ramoval from Stata

20b. Place of Disposition (Nama of cematary, crematory or other place) MARYLAND VETERANS CEM.

SEAT PLEASANT, MD

20c. Location - City or Town, State CHELTENHAM, MARYLAND

4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvica Licensee

0) 23a. Part 1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

22. Nama and Addrass of Facility Marshall's Funeral Home of MD

2-3-00

4308 SUITLAND RD. SUITLAND, MD

Immediata Causa (Final disaase or condition resulting In daath)

Due to (or as a cor

Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably **W**Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to

2 NO

completion of cause of death? 20 No

Approximate intarval Batween Onsat and Death

25. Was casa rafarred to medical axaminer? 1 ☐ Yes 2 No

27 Mannar of Death 5 Pending Invastigation 1 Natural 2 Accidant

6 Could not be

Hospital: 28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 28b. Tima of

3/200A 28c. Injury at Work?

Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 28d. Describe how Injury occurred

1 TYas 2 No

29a. Cartifiar (Check only one)

3 ☐ Suicida

4 Homicide

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, Stata)

29b. Signatura and titia of certifiar

29d. Data signed (Month. Day, Yaar)

CASEY

who complated causa of daath (Item 23a) (Type, Print) 30. Nama and addrass of per

3001 Hospital Drive Chevely, MD 20784

State Registrar

JASON 31. Data filad (Month, Day, FEB 0 1 2000

Registrar's Signatura

DHMH 16 Rev 6/95

1 X Cartifung Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number D34526

26. Placa of Death (Check only ona)

the the state of t

With I dillower to be still

State of Maryland / Department of Health and Mental Hygiene \bigcap

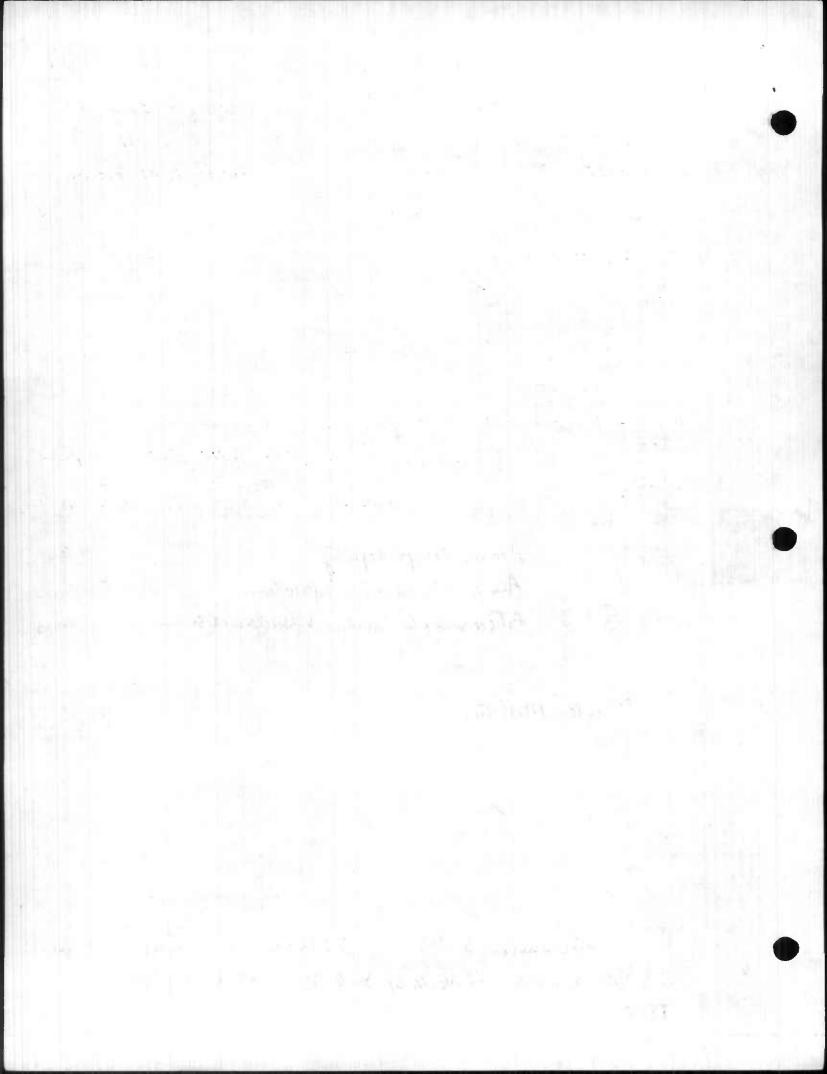
05086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 30, 2000 **Physician** ROSAMOND S. DEWS 1:35 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 3/29/50 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-54-3015 1□M 2\ F Wash., D.C. Director **Usual Residence of Decedent** the Meryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or frame 23s or 28s-f show the Medical Examiner must be notined at Prince George's Md. Cheverly Director N☐ Yes 2☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2407 57th Avenue 20785 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effect. Department of Health and Mentel Hygiene. Introduce in the marked other than "natural, or than any injury or other traumatic event, the terminal page." Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0020 1 Yes 2XXNo Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs. yrs. Transportation Aide School System 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) B John L. Shelton Amelda Blue 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald O. Dews/Husband 2407 57th Ave., Cheverly, Md. 20785 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremetion 3 ☐ Removel from State Ft. Lincoln Cem. 2/5/00 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. an rall 4925 Burroughs Ave., N.E., Wash., D.C. 20019 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the buriel-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed agents.) Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown bengis Records, þ The lew requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 2 No 1 Yes 2 No Division of Vital Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 100 funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural n 24 hours efter deeth.

Ne Funerel Director: After pletely filled in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 8 Hospital 29a. Certifie Medical To the Hosp within 24 hos To the Fune completely fi 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year) anuary eted cause of death (Item 23a) (Type, Print), 31. Date filed (Month, Day, Year) 32 Hagistrar's Signeture State FEB 0 2 2000

Registrar **DHMH 16 Rev 6/95**

State of Maryland / Department of Health and Mental Hygiene 0 05087

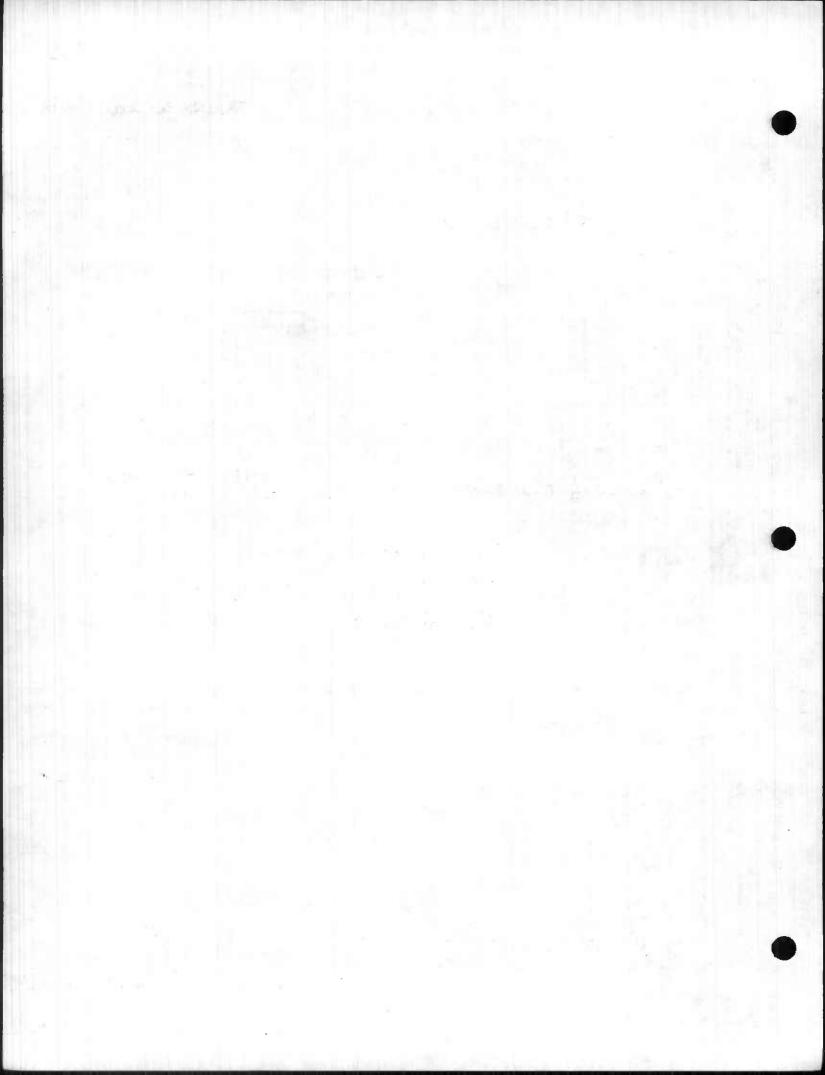
| | | | Certifica | te of Death | Re | g. No. | 03001 |
|-----------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------|-----------------------------------------|-----------------------------------------|-----------------------------------------------|
| | 1. Decedent's Name (First, Middle, Last | | | | 2. Dete of Death | | 3. Time of Death |
| Physician /Medical | Jess | Daniels | | | February | | 11/2/ |
| Examiner | 4a Facility Name (If not institution, give | street and number) | | 4b. City, Town, | or Location of Death | 4c. County of | |
| | Union Hospi | tal | | EIKto | on | Ceci | 1 |
| uneral | 5. Social Security Number 6. Se | 7. Age (In yrs. | | er 1 Year If Under 24 H | | | Birthplaca (State or Foreign Country) |
| rector | 216-32-1952 18 | ¥M 2□F | 2 Yrs. Month | s Days Hours M | February | 17. 1937 | West Virginia |
| | Usual Residence of Decedent | | | | 7 | | 3 |
| 1 | 10s. State 10b. County | | ty, Town or Location | | | | 10d. Inside City Limits |
| Ó | Maryland Cecil | | Elkton | | | | 1 ☐ Yes 2 ☑ No |
| Director | 10e. Street and Number | | 101. 2 | Cip Code | 10 | g. Citizen of Whe | at Country? |
| 0 | 71 Red Hill | Road | | 21921 | | 4.5.1 | 4. |
| Funeral | 11. Marital Status | 12. Was Decedent Ever in U | I.S. 13. Was Dec | edent of Hispanic Origin? secify Cuban, Mexican, Pu | (Specify Yes or No- | | American Indian, |
| Ē | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 ☑ No | | , | erto Rican, etc.) | | White, etc. |
| ρ | 3 Widowed 4 □ Divorced | If Yes, Give Year or Dates: | 1□ Yes | 2 No Specity: | | Specify: | White |
| | 15. Decedent's Edu | cation | 16a. Decedent's Us | ual Occupation | | 16b. Kind of Busin | ness/Industry |
| Completed | (Specify only highest grad | | (Give kind of the life. DO NOT | vork done during most of v use retired) | | | f Elkton |
| E | Elementary/Secondary (0-12) | College (1-4or 5+) | General | Maintenac | P | Public | Works |
| ŏ | 17. Father's Name (First, Middle, Last) | | 30.0.0 | | leme (First, Middle, N | | ,,,,,, |
| Be C | No informa | tion | | | a Dan | | |
| P | | | 10h Mailine Add | | | | ate. Zin Codel |
| | 19a. Informant's Name/Relationship (T) David A. Daniel | | | ss (Street and Number or | | - | |
| | | | 11 Red | Hill Road | RIKTON | 20c. Location - Cit | 21921 |
| | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F | Removal from State | Place of Disposition (A cometery, cremetory of | other place) | | | |
| - | 4 □ Donation 5 □ Other (Specify) | 611 | pin Manorl | hemorial Park | 2/7/2000 | EIKTON | , maryland |
| d | 21. Signature of Furnital Service Liceou | 00 | 22. Name | and Address of Facility | fee Fun | eral He | ome. |
| 3 | 23a. Part1. Enter the disease, or compi shock, or heart failure. List only o | 4 | 250 | = 10 = 1 = | =10.15 | -/// | 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 |
| | 23a, Part1. Enter the disease, or compl | utions that caused the deal | th. Do not enter the m | ode of dving, such as card | iac or respiretory erre | Ikton, II | Approximate |
| ian | shock, or heart failure. List only o | ne sause on each line. | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , , , , , , , , , , , , , , , , , , , , | | Onset and Death |
| ari ai | Immediate Cause (Final | 1 6 | 2 / 1 | 11- | | | 111 |
| r | disease or condition resulting in death) | Anoxic & | ncephalog | Jally | | | 11cours. |
| 5 | | An Due to (| or as a consequence o | 0 / 1 - | | | 111 |
| Examiner | | b. Make 1 | Mocardea | 2 Infarcte | ne | | 11 days |
| × | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | A /T Due to (c | or as a consequence o | 1/200 | lan dise | | 7.0 |
| | cause. Enter Underlying Cause (Disease or injury that initiated events | . Alherosch | esolie Ca | rdio vascu | lon aise | mse | years |
| edical | resulting in death) Last | Due to (c | or as a consequence of |): | | | |
| - 5 | | 1 | | | | | |
| Physician/ | | | | | | | |
| - S | Part It. Other significant conditions con | | ulting in the underlying | cause given in Pert I. | 23b. Did to | bacco usa contri | buts to the cause of death? |
| Phy | Diabetes | Mellitin | | | 1 🗆 Yı | ne 2□No 3 | Probably 4 Unknown |
| þ | | , rough | | | - | | |
| ed by P | | | | | 24e. Wes er | | 24b. Were autopsy findings available prior to |
| 9 | | | | | - | lou! | completion of cause of death? |
| Completed | | | | | 100 | s 20 No | 1 Yes 2 No |
| | 25. Was case referred to medical | | | | | | 1 1 10 5 2 LI NO |
| 0 0 | examiner? | lospital: | | Other | Seeth (Check only on | | |
| - | 27. Manner of Death | 1 Inpatient 2 | ER/Outpatient 3 1 | ALI Nursing | Home 5 Reside | | |
| Certification: | 1 ☑Natural 5 ☐ Pending | (Month, Day Year) | Injury | 28c. Injury at Work? | 200. Describe no | w injury occurred | |
| Cat | 2 Accident investigation 3 Suicide 6 Could not be | | М | 1 Yes 2 No | | | |
| 듣 | 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Special | ome, ferm, street, facto by) | ory, office | 281. Location (Str. City or Town | state) | or Rural Route Number, |
| Ö | | | | | | | |
| edical | 29a. Certifier 1 Certifying Phys | sician: To the best of my kno ner: On the basis of examina | wiedge, death occurre | d at the time, date and pla | ce, end due to the ca | usa(s) and mann | er as stated. |
| | ane) | and manner stated. | ation allow investigate | , in my opinion, obatir oc | correct at the time, ce | no ano piace, and | 3 000 to the Cause(s) |
| Σ | 29b. Signature and title of certifier | | | 9c. License number | | | Month, Dey, Year) |
| | Ala | show SI | (4) | 223322 | | Februs. | ne 8,2000 |
| | 30. Name and address of person who co | moleted cause of death (fee | n 23a) (Type Print) | | | , , , , , , , , , , , , , , , , , , , , | 21. |
| | S.S CARLINGAL | MD 118 11 | ns to Sa Si | 416-3B | Elpton . | MA219 | 21 |
| | 31. Date filed (Month, Day, Year) | / 32. Registrar's Signy | fura J | 1.200, | -2011 | 1)011 | 17 |
| State | FFR 0 8 2000 | Deput L | . spork | 2 | | | |



State of Maryland / Department of Health and Mental Hygiene 00 05088

| | | | | | | Ce | rtificate | of I | Death | | | Reg. No. | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------|--------------------------------------|------------------------|------------------------------------------------|------------------------------------|-------------------------------------|----------------|----------------------------|------------------------|----------------------------------------|----------------------------------|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| | | 1. Decedent's Name | a (First, Middle, L | | | | | | | | 2. Dete of De Month | ath Dev | Year | 3. Time of Death | | |
| Physic /Medi | | Adele | J. | | Dragnio | ch | | | | | Januar | | 000 | 12:24 A.M. | | |
| Exami | | 4a Facility Nama (I | | | | | | - 1 | | | ocation of Death | | y of Death | | | |
| | | Collingt | | | | | | | | | ville | | | | | |
| Funeral | | 5. Social Security N | | Sex 1□ M 2Ø F | 7. Age (In yn | s. <i>last birthday,</i> O Yrs. | Months D | ays | Hours Hours | 24 Hrs. Min. | 8. Data of Bir (Month, Da | | | placa (State or Foreign ntry) | | |
| Director | | 415-64-56 Usual Residence of | | | 0. | , ,,,,, | | | | | September | er 28 191 | 0 Ut | ah | | |
| or a m | | 10a. Stata | 10b. County | | | City, Town or L | ocation | | | | | | | 10d. Inside City Limits | | |
| death with the Maryland res 23e or 28a-f show Lossit be notified at | to | Maryland | Prince | Georges | | Bowi | е | | | | | | | Yas 2□No | | |
| 7 P | Director | 10e. Street and Nur | nber | | | | 10f. Zip Co | de | | | | 10g. Citizen of | What Cou | ntry? | | |
| 9 88 | | 10450 Lot | tsford R | oad # 2 | 31 | | | 20 | 721 | | | United | Stat | es | | |
| | Funeral | 11. Merital Status | | 12. Was Dec Armed F | cedent Ever in orces? | U,S. 13. | Was Deceden If Yes, specify | t of H Cuba | ispanic Or In, Mexica | igin? (Sp n, Puerto | ecify Yas or No Rican, etc.) | - 14. Ra Bk | ce - Amari | 12:24 A.M corges placa (State or Foreign ntry) tah 10d. Inside City Limits by Yas 2 No ntry? ces can Indian, etc. 1ite dustry Approximate Interval Bahween Onset and Death Lweek to the cause of death? well by Yas to the cause of death? well by Yas well by Yas Were autopsy findings wellable prior to modelth? Tyas No | | |
| | þ | 1 Never Marri | ied 2⊠ Married 4 ☐ Divorced | 1 Tes, G Year or I | 2 No ive Dates: | | 1□Yes 2页 | ζNo | Specify | | | Speci | y: Wh | ite | | |
| Tanta de la constante de la co | letec | (Spec | 15. Decedent's E | |) | (Give | dent's Usual O | lone (| during mos | at of work | ing | 16b. Kind of I | 3usinass/In | Death Georges Birthplaca (State or Foraign Country) Utah 10d. Inside City Limits 10d. Inside City L | | |
| 21215-0020 of within 72 hours at gleno. or then "natural, or t the Medical Exam | Completed | Elementary/Seco | ndary (0-12) | College 5+ | (1-4or 5+) | | DO NOT use i | elirec | " | | | Med | ical | | | |
| Maryland 2 d 2 should be filed th and Mental Hygis T is marked other traumatic event, is | To Be | 17. Father's Name (Frank W | | - | | | | | | | e (First, Middle, Czapje | | me) | | | |
| Aar 2 sho 2 sho 1 mm | *** | 19a. Informant's Na | | | | | | | | | al Routa Numb | | | Code) | | |
| * 234 F | | | Alex N. Dragnich/ Husband 10450 Lott | | | | | | | 1. # | | | | | | |
| altimore mit. Pages 1. partment of He portant: If then y injury or oth | | 20a. Method of Disp 1 Burial 2 | cosition ☐ Cremation 3 [| ☐Removal from | | cometery, cre | matory or othe | r plac | æ) | Ja | Data Inuary 28 | | | | | |
| Itims rhant rhant | | | 5 Other (Spec | | Me | edical | Center_ | | | | 2000 | Wasiiii | igcon | , D.C. | | |
| Balt Permit. Departments Imports Imports any Inja | | 21. Signature of Fu | neral Service Lick | 7. 0 |) | | 2. Name and A Olumbia | | | | Services | Inc. | | | | |
| | | 23a. Parts Enter th | Adienses or ov | polications that | 2- | P | .O. Box | 5 | 8007 | Wash | ington, | D.C. | 20037 | | | |
| Physician | | shock, or hear | rt failure. List only | y one cause on | each line. | aur. Do not on | to the moos o | . Oyai | y, such as | Carolac | or respiratory a | 11031, | 1 | Interval Batween | | |
| /Medical | | Immediate Cause (disease or condition resulting in death) | Final n | a | Caro | (or as a conse | 1/n0. | 10 | my | an | rest | | į | _ | | |
| | 5 | Tesuring at Coacity | | | Due to | DI | | | | | | | 1 | 7 | | |
| uted | Examiner | 0 | | b | Dunto | (or as a conse | 12 C | | | | | | i | Iweek | | |
| death certificata be executed to attending physician and ed for use as the buriel-transit | | Sequentially list coil any, leading to imcause. Enter Unde Cause (Disease or that initiated events | nditions, nmediate orlying | | 500 10 | (Or as a conso | quance or). | | | | | | | | | |
| 68760, ifficets be ext g physician as the buriel. | edical | Cause (Disease or that initiated events resulting in death) I | injury | Due to | (or as a conse | quence of): | | | | | | 1 | | | | |
| X 6 | 2 | | | l d | | | | | | | | | | | | |
| BO) | lan | | | 0 | | | | | | | | | I | | | |
| P.O. hat the ded by the | Physician/ | Part II. Other signifi | | - | | | inderlying caus | e giv | en in Part | l. | | ./ | | | | |
| es that the ligned by the be deteched | 4 | Ho | ortic | Ste | 00515 | | | | | | 10 | Yes KONO | 3 Pro | bably 4 Unknown | | |
| Orc oqui | Completed by | C | onges | tire | Hear | + 4 | -ails | re | | | 24a. Wes | an autopsy ormed? | 81 | vailable prior to | | |
| The law ate hes b | idm | | teopos | | L | 1. | . 1 / | 4 | / 1_1 | | | _ | of | death? | | |
| | ပိ | 25. Was case refer | | 5160 | With | im po | 11001 | 0 | | | 10 | | 1 | Yas ZUNO | | |
| of Vital Physician: this certificanal director, p | 0 0 | axaminer? | | Hospital: | Inpatient 2 | □ ER/Outpatio | et all now | Oth | | | h <i>(Check only o</i> oma 5 ☐ Rasi | | har /Snaci | ihe) | | |
| ang Phys | i i | 27. Manner of Death | 1 | 1 | of Injury ofth, Day Year) | 28b. Tima d | | Injun | | ursung i te | 28d. Describe | | | 97 | | |
| Attending or death. | atio | 2 Accident | 5 Pending investigation | on | iii, Day rear) | Injury | М | | Yes 2 | No | | | | | | |
| Division or Attending effer death. Director: After d in by the fune | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not l | 4 288. PIBC | e of tnjury - At ling, etc. (Spec | home, farm, st | reet, factory, o | ffice | | | 28f. Location (City or To | Street and Num wn, State) | ber or Rur | al Routa Number, | | |
| O PER PER | | | · | | | | | | | | | | | | | |
| Division of the Hospital or Attending Phyminia 24 hours elser death. To the Funeral Director: Affer th completely filled in by the funeral | edical | 29a, Certifier (Check only one) | Certifying P 2 | miner: On the b | a bast of my knoasis of axamin near stated. | nowledge, deat nation and/or in | h occurred at to restigation, in | my o | na, date ar pinion, dea | nd place, ath occur | and due to the red at the time, | causa(s) end n date end place | nanner as a , and due t | stated. to the cause(s) | | |
| o the | ž. | 29b. Signature and | title of certifier | | | | 29c. L | icens | e number | | | 29d. Data sign | ed (Month, | Day, Year) | | |
| F 3 F 0 | | | Sto | J | 7 | Lan | | T |) 37 | 793 | 34 | Jan | , 2 | 8 2000 | | |
| | ŀ | 30. Name and addre | ess of person who | completed cau | se of death (Ite | em 23a) (Type, | | | | | | | | 8 2000 20770 en 4/+ MB | | |
| | | | phanie | Trifo | glisp | D | 7500 | (| Green | n way | (estis | Dive | Gre | en be It MD | | |
| Sta | | 31. Dete filed (Mont | n 9 2000 | 32.1 | Registrar'a Sign | nature | | | | | | | | | | |
| Regist | | 760 | A # 5000 | 10 | fere | 15. | bar | | ,- | | | | | | | |
| DHMH 16 Rev 6/9 | 5 | | | • | | , | 3 | . 7 | | | | | | | | |

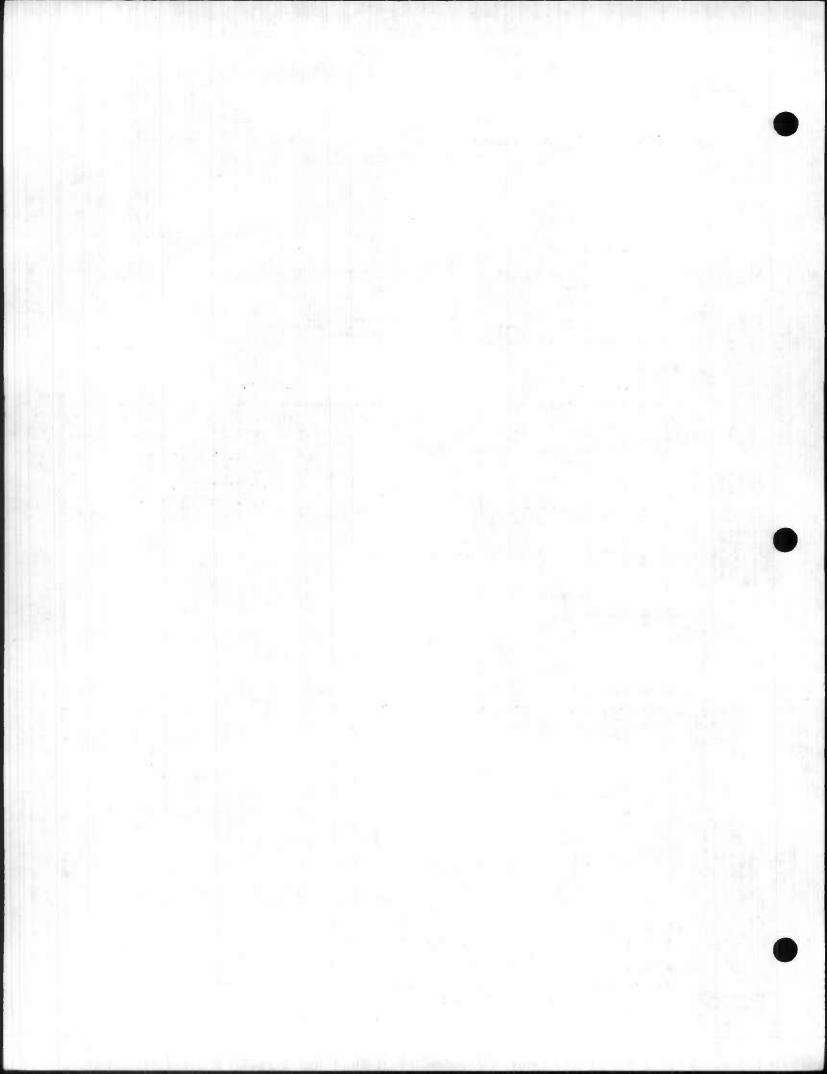
Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cappa \)
| | | | | | | Cert | ificate of | Death | , | Reg. No. | 0.0 | 000 |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------|-----------------------|-----------------------------------|-------------------------------------------|-------------------------------|-------------------------------|--------------------------------|-------------------------------------|
| | | _ | 1. Decedant's Nama (First, Middla, La: | st) | | | | | 2. Data of De Month | eath | Year | 3. Time of Death |
| | Physician /Medical | - | EDNA MAY | DALEY | | | | | DAVUS | Day 24 30 4 | 2000 | 0212 |
| | Examiner | | 4a Facility Nama (If not Institution, give | a street and number) | | | | 4b. City, Town, or | Location of Deat | | | |
| 4 | | | Washington Cou | nty Hosp | oital | | | Hagers | town | Wash | ingto | n |
| | Funeral | | 5. Social Security Number 6. S | ex 7. Ag | e (In yrs. la | st birthday) | If Under 1 Year Months Days | | | rth | | e (State or Foreign |
| | Director | - In | 214-28-3146 | ДM 2□F | 71 | Yrs. | July 5 ay 5 | 710010 | Aug 7, | | Frankli | n Co, PA |
| | 2 * | - H | Usual Rasidence of Decedant 10a. Stata 10b. County | | 10a Cibe | Town or Loca | tion | | | | 104 | haid- Chat into |
| | aryta ashon sd ast | | | | | | | | | | 100. | . Inside City Limits 1 ☐ Yes 2 ☑ No |
| | or 28s-f st be notified Director | - | MD Washing | ton | Hage | erstown | | | | | | |
| | § 28 B | | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of V | What Country | 7 |
| | r here death w | 6 | 16866 Shinham RD | | From in 11 C | 40.141 | 2174 | | > | US | A | Indian |
| | Br des Berms Der m | 5 | 11. Marilal Slalus | 12. Was Decedent Armed Forces? | | . 13. W | as, specify Cub | Hispanic Origin? (5 san, Mexican, Puer | to Rican, etc.) | Blac | e - American ck, Whita, etc | |
| 20 | of, or the by F | | 1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑1 If Yas, Giva Year or Dates: | NO | 10 | Yes 2∏No | Specify: | | Specify | Whit | e |
| 21215-0020 | | | 15. Decedent's Ed | 12 17 17 17 17 17 17 17 17 17 17 17 17 17 | | 16a Deceder | nt's Usual Occup | nation | | 16b. Kind of Bu | usiness/Indus | try |
| 15 | ed within 72 ho ygiens. Ner than "natural, the Medical. | | (Specify only highest gra | de completed) | | (Giva ki | nd of work done NOT use retire | during most of wo | rking | | | , |
| 27 | The Bank | 5 | Elementary/Secondery (0-12) | College (1-4or 5 | 0+} | Hon | nemaker | | | Own Ho | me | |
| | tal Hyg d other event, Be C | 2 | 17. Fathar's Name (First, Middla, Last) | | <u>'</u> | 1100 | | 18. Mother's Na | me (First, Middle | , Maiden Suman | | |
| ā | Menta Menta Infe en | 3 | Andrew Jackson | Adams | | | | Ethel | Frances | Brown | | |
| Maryland | Short Management | | 19e. Informant's Name/Relationship (| Type, Print) | | 19b. Meiling | Address (Street | t and Number or R | ural Route Numb | er, City or Town, | State, Zip Co | ode) |
| | aith a 27 ly | | Richard L. Daley | Husband | | 16866 | Shinham | n Rd Hag | erstown | MD 21 | 740 | |
| ore, | THE STATE OF THE S | | 20a. Method of Disposition | | 20b. Pla | ce of Disposit | ion (Nama of tory or other pla | ice) | Date | 20c. Location - | City or Town | , Stata |
| Ĕ | Page net if | | 1XX9urial 2 ☐ Cramation 3 X 4 ☐ Donation 5 ☐ Other (Specifi | | | | Hill Chu | | 02/04 | Antrim Frankli | | |
| Saltimore, | The state of | | 21. Signature of Funeral Service Licen | 69 | | 22.1 | Name and Addre | ess of Facility | · | rove Fun | eral H | lome |
| m | Por Fig. | | James A. Bowe | Sowerse | y | 52 | 21 S Was | hington | | | | 17225 |
| | | + | 23a. Part. Entar tha disaase, or companies hock, or haart feilure. List only | | tha death. | | | 0 | | | . At | pproximate |
| | Physician | | Shock, or heart tellure. List only | ona cause on each in | 10. | | | - | | | | terval Between nset and Death |
| | /Medical | | tmmediata Causa (Final disaasa or condition | Car | oven | 1 20 | Keins. | Luzeas | - | | Î t | |
| | Examiner | | rasulting in daath) | a | | as a conseque | ance of): | duseas | | | 1 | |
| ь | je je | | | Di | late | dia | 1.00 | cocality | un op | the | l i | |
| | physician and s the burist-transit | | Sequentially list conditions, | b | Dua to (or a | is a conseque | | Carago | 77) | V | 1 | |
| 0 | ian a urial-l | | Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaase or Injury that initiated events | H | 10.1.1 | Windo | un 16 | | | | i | |
| 68760, | g physician as the buria | | that initiated evants rasulting in death) Last | c | Due to (or a | s & conseque | nce of): | | | | | 1 P F0 |
| | E 0.6 | | Tabling in addity 2001 | | | | | | | | 1 | |
| Box | tendii or use | | _ | d | | | | | | | t | |
| | that the death certi ed by the attending detached for use a | | Part II. Other eignificant conditions co | ontributing to death be | ut not result | ing in the und | erlying cause gi | ven in Part t. | 23b. Did | tobacco use co | ntribute to th | ne cause of death? |
| P.0 | that the sed by the detache | | | | | | | | 10 | Yes 2 No | 3 Probab | bly 42 Unknown |
| Ś | be be | | - | | | | | | | | | |
| Records, | The law requires pate hes been sign page 2 should be Completed b | | | | | | | | | an autopsy omed? | availa | autopsy findings |
| 90 | > 0 0 | | | | | | | | | | of der | eletion of cause ath? |
| 8 | The la | | | | | | | | 10 | Yas 2 DNO | 10Y | es 20 No |
| Vital | raician: The lav s certificate has director, page 2 To Be Comp | | 25. Was casa rafarred to medical axaminar? | | | | | 26. Place of De | ath (Check only | one) | | |
| of V | 0 0 | | 1 Yas 2 No | Hospital: 1 ☐ Inpalie | nt 200e | FVOutpatient | 3 DOA Ot | her: 4 Nursing I | Home 5□Res | idence 6 Oth | er (Specity) | |
| 0 | After It funeral funer | | 27. Mennar of Death 1 ☑ Naturat 5 ☐ Panding | 28a. Deta of Inju (Month, Day | y Year) 2 | 8b. Tima of Injury | 28c. tnju Wo | ry at rk? | 28d. Describe | how injury occur | red | |
| 0 | Attending or death. octor: After by the fune iffication | | 2 ☐ Accident investigation | | 1075 | | M 1□ | Yes 2□No | | | | |
| Division | tef or Attending P rs after death. ef Director: After bed in by the funers Certification: | | 3 Suicide 6 Could not be datarmined | 28e. Ptece of Injubulding, etc. | | e, ferm, stree | t, factory, office | | 28f. Location (City or To | Street and Numb wn, Stata) | er or Rural R | loute Number, |
| | is after or led in Cert | | | | | | | | | | | |
| | in 24 hour in 24 hour he Funer pletely fit | | (Check only 2 Medicat Exam | vsician: To the best of liner: On the basis of | of my knowle | edge, death o | ocurred at the ti | me, date and plac | e, and due to the | cause(s) and me | anner as state | ed. en cause(s) |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | | one) | and manner sta | ited. | | | | | | | |
| | O T W T O | | 29b. Signature and title of certifier | 1 | 1 | | 29c. Licens | se number | | 29d. Data signe | (Month, Day | y, rear) |
| | | | Feet | | 1 | | 100 | 04113 | 7 | 43 | 0/20 | 900 |
| | | 1 | 30. Name and address of person who t | completed course of d | eath (Item 2 | 3a) (Type, Pr | int) | 334 | will | 57. | 1 | |
| | | 1 | WERRY | L. 60/2 | 1000 | 5), | 4.17. | Here | persto | wn d | no. | 21740 |
| | State | | 31. Date filed (Month, Day, Year) FEB 0.2 201 | 32. Røgistri | ar's Signatu | ra La | Ana " | , ! | | | | |
| | Registrar | | FED U & ZU | 30 | | 1. | papione | 2 | | | | |



State of Maryland / Department of Health and Mental Hygiene 00 05090

| | | | | Certificate | e of Dear | th | | Reg. No. | J | 203 | U |
|-------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|----------------------------------------------------|--------------------------------|-------------------------------------------|------------------------------------|-----------------------------------|---------------------------------------------------------|-----------------|
| | 1. Decedent's Nama (First, Middle, Last) | | | | | | 2. Data of Dea | | Year | 3. Tima o | Death |
| sician ledical | MARVIAN VIRGINI | A DALEY | | | | | JANUA | | | 8;3 | MA O |
| aminer | 4a Fecility Nama (If not institution, give s | street and number) | | | 4b. City, | Town, or Loc | ation of Death | 4c. County | of Death | | |
| | RAVENWOOD LUTHERA | | | | | ERSTOW | | | INGTO | | |
| eral tor | 220 42-3303 | 7, Age (In yrs. | 83 Y | Months | Days Hou | s Min. | B. Date of Birtl (Month, Day Jan. 1 | r, Year) | 9. Birthp Cour Ma | olace (Stata o otry) rylano | or Foreign 3 |
| | Usual Residence of Decedent 10a. Stata 10b. County | 100 0 | h. Tourn | or Location | | | | | T | Od Incide C | Day & London |
| ctor | Maryland Washingto | | | gerstown | 1 | | | | | 10d. Inside C | 2 No |
| al Directo | 10e. Street and Number 1330 Potomac Aven: | ue | | 10f. Zip | Code 217 | 42 | | 10g. Citizen of V | What Cour U.S | • | |
| by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; |),S. | 13. Was Deced If Yes, spec | lent of Hispanic city Cuban, Mexi EN No Spec | | ify Yas or No- lican, atc.) | Blac | e - Amaric ck, White, : Whi | | |
| pete | 15. Decedent's Educ (Specify only highest grade | cation | 16a. l | Decedent's Usua (Give kind of wor | l Occupation | nost of workin | 0 | 16b. Kind of Bu | usinass/In | dustry | |
| Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | 1 | ille. DO NOT us nemaker | e retired) | TOOL OF WORKING | | Own Res | sider | ice | |
| | 17. Father's Nama (First, Middle, Last) | 0 | 1101 | iiciico ici | 18 M | ther's Name | (First Middle | Maiden Suman | 10) | | |
| o Be | Earl W. Hepperle, | Sr. | | | | lary Ne | | Walder Comun. | 0) | | |
| Ĕ | 19a. Informant's Name/Relationship (Ty) | | 19h | Mailing Address | | | | r City or Town | State 7is | Code) | |
| | Harry Raymond Dal | | | 1 Hamel | | | | | | | 01 |
| | 20a. Method of Disposition 1 (XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify) | amount from State | cemetery | Disposition (Name, crematory or of Haven Co | ther place) | Ja | Data an. 29 | 20c. Location - | | | and |
| | 21. Signature of Funeral Service License | | | 22. Name and | d Address of Fa | cility | | | | 7 | |
| | Dienolo A | / Finy | | 1331 E | s A. Fi astern | ery Fur Blvd., | N., Hage | erstown, | Mary | land 2 | 21742 |
| | 23d. Part1. Enter the disease, or complications, or heart failure. List only on | cations that caused the deal e cause on each line. | th. Do n | ot enter the mode | e of dying, such | as cardiac or | respiratory ar | rast, | 1 | Approximation interval Bet Onset and | tween |
| | Immediate Cause (Final disease or condition | | | 1/17/ | 2000 | | | | | | |
| | resulting in death) Bue to (or as a consequence of): | | | | | | | | | MANY | |
| Examiner | | HYPERTENSI | ON | | | | | | 1 | YEAR | S |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (d | or as a co | onsequence of): | | | | | 1 | | |
| Medical | that initiated events resulting in death) Last | Due to (c | or as a co | onsequence of): | | | | | | | |
| Physician/ | | | | | | | | | Î | | |
| ysic | Part It. Other significant conditions con | | | | | | | obacco use co | | | / |
| þ | PREVIOUS STROKE | AND TRANSIE | NT I | SCHEMIC | ATTACKS | | 10 | res 2□ No | | | Unknow |
| Completed | | | | | | | | an autopsy med? | av. | are autopsy railable prior empletion of death? | to |
| 5 | | | | | | | 101 | as 20 No | 11 | ☐ Yas 2☐ | No |
| BeC | 25. Was case referred to medicat | | | | 26. P | ace of Death | (Check only o | ne) | 1 | | |
| To | examiner? 1 Yes 2 No | ospital: 1 Inpatient 2 | ER/Out | patient 3 DO | Other: 4 E | Nursing Hom | a 5 Resid | lence 6 Oth | er (Specia | (y) | |
| Certification: | 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation | 26a. Data of Injury (Month, Day Year) | 28b. Ti | me of jury M | 8c. Injury at Work? 1 ☐ Yes 2 | | 8d. Describe h | now injury occur | red | | |
| Cermic | 3 Suicide 6 Could not be detarmined | 28e. Place of Injury - At h building, etc. (Specia | | m, street, factory | , office | 2 | 8f. Location (5 City or Ton | Street and Numb m, State) | er or Run | al Routa Nun | nber, |
| edical | 29a. Certifier (Check only one) | ician: To the best of my knower: On the basis of examina and manner stated. | wledge, ition and | death occurred a /or investigation, | at the time, data in my opinion, | and place, ar death occurre | nd due to the d d at tha tima, d | cause(s) and ma date and place, | inner as s and due t | stated. the cause(| s) |
| × | 29b. Signature and title of certifier | | | 29c | . License numb | er | | 29d. Date signe | d (Month, | Day, Year) | |
| | 30 Name and address of assess of | Mary 1 | 7 22-1 0 | Turne Print' | D07859 | | | JANUARY | 27, | 2000 | |
| | 30. Nama and address of person who con Dr. Edson Moody M | | | | Насез | stown, | Md. | 21740 | | | |
| 1010 | 31. Data filed (Month, Day, Year) | 32. Redistrar's Signs | | Liia Nu. | nagel | . S LUWII, | riu. | 21/40 | | | |
| State | VAN 3 1 200 | 10 Super | / | G. pp | racks | | | | | | |

Marvian Virginia DALEY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 9 1

| | | | | | Cert | tificate of | Death | | Reg. No. | | | | | |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------|------------------------------------|-------------------------------------------|----------------------------------------------|--------------|--|--|
| | Observato) | | 1. Decedent's Name (First, Middla, Last) | | | 2. Date of D | 2. Date of Death | | 3. Time | of Death | | | | |
| ęį. | Physicia /Medic | | MILTON M. DANIELS, | Sr. | | | | 01 | 24 | 00 | 7:45 | 5 am | | |
| | Examin | | 4a Facility Nama (If not institution, giva street and number) | | | | | or Location of De | 4c. Cou Prin | nty of Death | | | | |
| | | | Southern Maryland Hospit 5. Social Security Number 6. Sex 7. Age In 1 | | tak at 1 | If Under 1 Yaer | Clinto | | Geor | ge's | | | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 86 Yrs. 1 Months 1 Months 1 Min. 1 Min | | | | | | | | | i or Foreign | | |
| | Nend Nend | | | . City, Tow | vn or Loc | ation | | -17 | | | 10d. Insida | City Limits | | |
| | Man | tor | MD Prince George's | Uppe | er M | arlbor | 0 | | | | 1 📉 Y s | s 2 No | | |
| | or 28 | Sr.ec | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen | of What Cou | ntry? | | | |
| | 23a | ral | 16103 Village Drive West | | | | 772 | | Unite | d Sta | ates | | | |
| 21215-0020 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Aygiane. If Health and Mental Aygiane. To it marked other than "natural", or frama 28a or 28a-f show other traumatic event, the Medical Examinar must be notified at | by Funeral Director | 11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 12. Was Decedent Ever in Armed Forces? 13. Was Decedent Ever in Armed Forces? | n U,S. | | /as Decedent of Yas, specify Cul ☐ Yas 2 1 No | | ' (Specify Yes or N Jerto Rican, etc.) | | lace - Ameri Black, White, city: B1 | etc. | | | |
| 5 | 72 h | To Be Completed | 15. Decedent's Education (Specify only highest grada completed) | 16a | . Decede | ent's Usual Occur ind of work done O NOT use retire | pation during most of | working | 16b. Kind of | Businass/In | dustry | | | |
| 121 | within than | | Elementary/Secondary (0-12) College (1-4or 5+) 9 th | | | <i>o NOT use retire</i> tenanc | | | Gov | ernme | ent | | | |
| 9 | Hygiene. Hygiene. Wher than | | 17. Fathar's Nama (First, Middle, Last) | | 10 111 | ochane | | Nema (First, Midd | | | | | | |
| lan | Mental Mental arked o | | Isacc Daniels | | | | Mary (Unknown) | | | | | | | |
| Maryland | ahould and Mer marks umatic | | 19a. Informant's Name/Relationship (Type, Print) | 191 | b. Mailing | Addrass (Stree | (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20772 | | | | | | | |
| | f Health of Health Heal | | | | | | lage Dr. West., Upper Marlboro | | | | | o, Md | | |
| altimore, | | | 20a. Method of Disposition | | | ition (Nama of atory or other pla | ice) | Deta | 20c. Locatio | | | | | |
| Ē | nit. Page artment o ortant: If i injury or E. | | 4 Donation 5 Other (Specify) | aryl | | Vets. | | 2-1-0 | Chel | tenha | ım, M | d. | | |
| Ba | permit. Page Department of Important: If eny injury or page. | | 21. Signiffine of Funeral Service Ligensee | | Ra | | lliams | Funera SE, Was | | | 03 | | | |
| | | | 29a. Part 1. Entar/tha disease, or complications thet caused tha d shock, or heart feitura. List only one cause on each lina. | seath. Do | not enta | r tha moda of dy | ing, such as car | diac or raspiratory | arrast, | | Approxim Interval B | etween | | |
| d | Physician /Medical | | Immediata Causa (Finat disease or condition | al (| ar | dias | Arro | Hania | | 4 | Onsat and | Death in 5 | | |
| | Examiner | _ | rasulting in deeth) Dua to | to (or as a | consequ | ience of): | 0 0 | of Art. | 7 | | | . ~ | | |
| | nei ted | nlne | b. 4no | Ler | 14 | | orona | of Itrt. | lvg L |)15. | 504 | 55 | | |
| , | n and lel-tra | Exar | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury c. | | | | | | | | | | | |
| 68760 | ificate be executed g physician and as the burlei-transit | edical Examiner | mat initiated events | Dua to (or as e consequence of): | | | | | | | | | | |
| | 5 D 4 | * | | | | | | | | | | | | |
| Вох | leath certifical attending pl | Sur. | d | | | | | | | | | | | |
| o o | the all | ysic | Part II. Other significant conditions contributing to death but not | rasulting I | In tha und | derlying cause g | iven in Pert I. | 23b. DI | d tobacco uae | contributa t | the caus | e of death? | | |
| 0.0 | hat the ed by detac | Ph | Apiration Pneumonia, a | won | ie K | enul 7 | ail me | 10 | Yes 20 N | 3 Pro | bably 4 | Unknown | | |
| Records, | law requires that the death cer les been signed by the attendin 2 should be detached for use | Completed by Physician/N | | | | le bili: | | | es an sutopsy formed? | av cc | Vare autops vailable prio pmpletion of | ir to | | |
| • | The lay ate hes page 2 | E C | , | | | | | 10 | Yas 28 No | | fdeath? □Yas 2l | □ No. | | |
| | ifficate tor. pu | Be C | 25. Was case refarred to medical | | | | 26. Place of | Deeth (Check only | 84 | | □ 185 ZI | J 100 | | |
| _ | Physician: The law this certificate hes b ral director, page 2 s | ToB | axaminar? 1 Yas 2 No Hospitat: 1 Inpatient 2 | 2 ER/O | utpatient | 3 DOA | her: | g Home 5□Re | | Othar (Speci | ify) | | | |
| Division of | Attending Physician: r death. ector: After this certific by the funeral director. | atlon: | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Deta of Injury (Month, Day Year | r) 28b. | Tima of Injury | 28c. Inju Wo M 1 | ıryat ork?]Yas 2 ☐ No | 28d. Describ | e how injury oc | urred | | | | |
| DIVIS | al or Afte s after de l Directo d in by th | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - A building, atc. (Special Coulding) | t home, fe | erm, stre | et, fectory, office | | | (Street and Nu own, Stete) | mber or Run | al Route Nu | mber, | | |
| | | edical | 29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my I 2 Medical Examiner: On the besis of axam and manner stated. | knowledge nination er | e, death o | occurred at tha t astigation, in my | ima, data and pl opinion, daath o | ace, and due to the | a cause(s) end a, data and plac | manner as s e, and due t | stated. to the ceuse | 9(s) | | |
| 1 | To the | Ž | 29b. Signatura and titla of certifiar | | | 29c. Licen | se number | | 29d. Date sig | ned (Month, | Day, Year) | | | |
| | 8 | | Ouch and G. Turson 1 | MD |) | Do | 2237 | MD | 1/20 | 1/00 |) | | | |
| | (2) | | 30. Name and addrass of person who completed cause of death (I | Item 23a) | | | + +1 | DIFI | 1.1. | hai | 20- | 244 | | |
| | | | 31. Data filed (Month, Day, Year) 32 Begistrar's Signature 1 | D I | 128. | 25011 | FORT | Ka Ft. | Wash | 1, 8M | V | 19 | | |
| | Stat Registra | | JAN 3 1 2000 | Prioring. | 4 | 1 | | | | | | | | |

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JAN 3 1 2000 Journey of Market

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If Under 1 Year

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Months

| land / Department of Health and Menta | l Hygiene | 00 | 0 | 5 | N | 9 | 1 |
|---------------------------------------|-----------|----|---|---|---|---|---|
| Certificate of Death | Reg. No. | | | | | | |

Physician /Medical Examiner

Director

Funeral

by

Completed

Be

Louis

Eber1e

2. Dete of Deeth Month **FEBRUARY** 3. Time of Death

Penrose 4e. Fecility Neme (If not institution, give street end number)

4b. City, Town, or Location of Deeth Leonardtown

2000 12:15A.M 4c. County of Deeth

Funeral Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, fire Magical Examiner frust be notified at

Pagas 1 and 2 should be filed within 72 hours efter or ant of Health and Mentel Hygiene. At: If Item 27 is marked other than "natural", or ite

permit. Pages 1 end 2 Department of Health au Important: If Item 27 Is any Injury or other trau

Physician /Medical

Examiner

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ettending physician for use es the burie

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has page 2

certificate

After

efter death.

Director: Aff
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within 24 hours of To the Funeral Di completaly filled Ir

director.

funeral

To the Hospital or Attanding Physician: within 24 hours efter death.

signed b

that the deeth certificate be axecuted

Box 68760

P.O.

Records,

Vital

Division of

Physician/Medical Examiner

Completed by

Be

Medical Certification: To

Baltimore, Maryland 21215-0020

the Marylend

death

219-10-9901 10a. Stete 10b. County

5. Sociel Security Number

10c. City, Town or Location

7. Age (In yrs. lest birthday)

If Under 24 Hrs. Hours Min.

January 24,09 Washington, D.C.

Birthplace (State or Foreign Country)

Usual Residence of Decedent

St. Mary's

Leonardtown

Yrs

10d. Inside City Limits 1∰Yes 2□No

Maryland 10e. Street end Number

10f. Zip Code

10a. Citizen of What Country? United States

St. Mary's

1 M 2 □ F

21580 Peabody Street

St. Mary's Hospital

12. Wes Decedent Ever In U,S. Armed Forces?

College (1-4or 5+)

Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

Race - American Indien, Bleck, White, etc.

1 Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced

I ☐ Yes 2 No If Yes, Give Yeer or Dates: 15. Decedant's Education (Specify only highest grede completed)

16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

White 16b. Kind of Business/Industry

Elementery/Sacondary (0-12) 12

Agent

US Government

Specify:

17. Father's Neme (First, Middle, Last)

John Jacob Eberle

Emma West Glading

19a. Informant's Name/Ralationship (Typa, Print)

P.O. Box 1207, Leonardtown, Maryland 20650

Joan E. Holmes / Daughter 20e. Method of Disposition

20b. Placa of Disposition (Nema of cemetery, cremetory or other place)

20c. Location - City or Town, Stete Dete

18. Mother's Neme (First, Middle, Maiden Sumeme)

19b. Mailing Address (Straat and Number or Rurel Route Number, City or Town, State, Zip Coda)

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete

Anatomical Board

2-11-00 Baltimore, MD

4 Donetion 5 ☐ Other (Specify) Edward N. Brinst

Edward N. Brinst, e1d. Jr, M00052 22955 Hollywood Road, Leonardtown, MD 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errast, shock, or haart failure. List only one cause on each line.

Brinsfield Funeral Home, P.A. 20650-0279

Immediata Causa (Final disease or condition resulting in death)

22. Name end Address of Fecility

Approximate Intervel Between Onset and Deeth

Sequantielly list conditions, if eny, leeding to immedieta cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 PNo

NA

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case rafarrad to medical exeminer? 1 Yes 2 No

27. Mannar of Death

1 Natural

2 Accidant

4 Homleida

3 Sulcide

5 Panding Invastigation 6 Could not be determined

Hospital:

28a. Pleca of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28b. Time of

Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Dascribe how Injury occurred

29a. Cartifian ☐ Medical Examine

🕼 Cartifying Physician: To tha best of my knowladga, daath occurred et tha tima, data and plece, and due to the ceusa(s) and mannar as stated. The basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the causa(s)

29b. Signature a of partities

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

JAMES JARBOE, M. D ed causa of daath (Itam 23a) (Type, Print) PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD, 20636

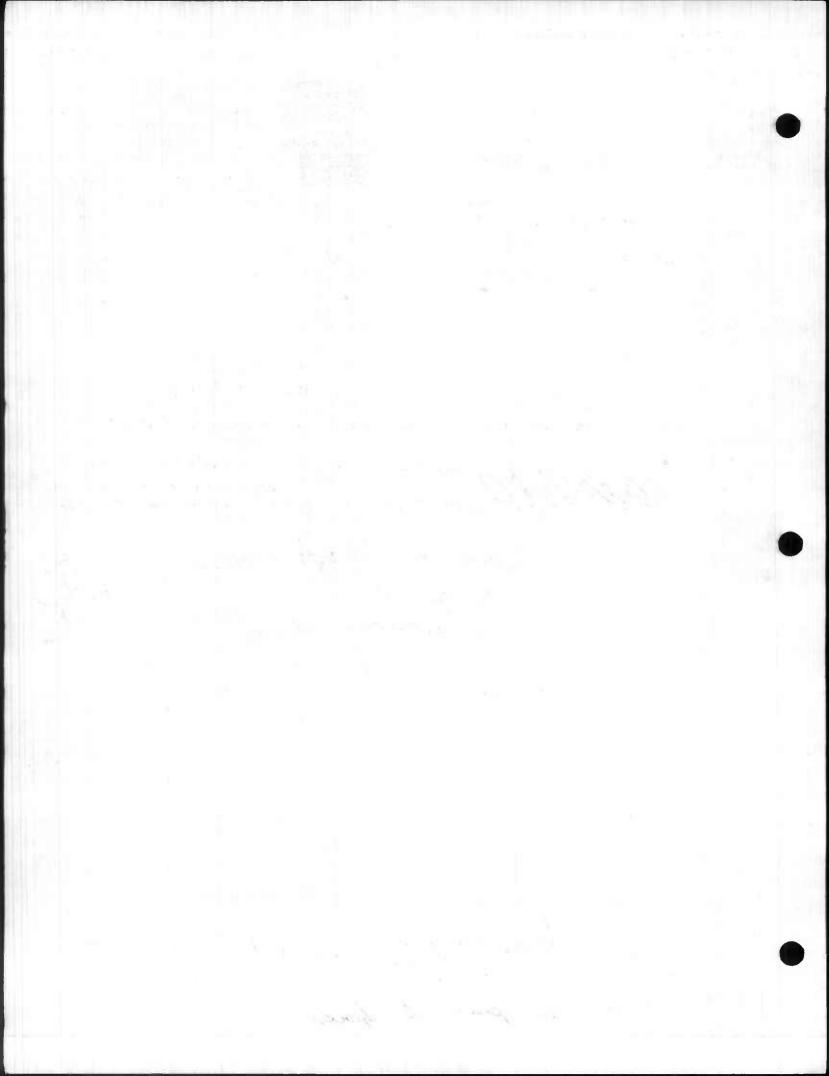
State Registrar

31. Date filed /M 5 2000

32. Registrar's Signature

oaks

EBERLE LOUIS NAME:



State of Maryland / Department of Health and Mental Hygiene 0 0 5093

| | | | Certificate of | Death | R | eg. No. | 0009 | 3 | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------|-----------------------------------------------------------|---------------|--|--|
| Dh | Decedent's Name (First, Middle, Last) | | | | 2. Dete of Deat Month | h Day | 3. Time o | of Death | | |
| Physician /Medical | George Robert Elder | | | 4b. City, Town, or L | Jan. | | 000 12:1 | 15pm | | |
| Examiner | Harford Memorial Hos | spital | | lavre de | Grace | Harfo | rd | | | |
| Funeral Director | 5. Social Security Number 216-09-3411 Usual Residence of Decedent | 7. Age (In yrs. last b | Yrs. Months Days | | 8. Date of Birth (Month, Day, 05/09/ | Year) | 9. Birthplace (State Country) Kentucky | | | |
| show show id.at | 10a. Stete 10b. County | 10c. City, To | wn or Location | | | | 10d. fnside (| City Limits | | |
| with the Maryland a or 28s-f show Lbs.notfilled.at | MD Harford 10e. Street and Number | Havro | e de Grace 10f. Zip Code | | 1 | 0g. Citizen of W | | | | |
| 23 and 12 | 113 Francis Street | | 21078 | | | USA | | | | |
| hours after death v hunt, or thems 23s at Examiner must ad by Funeral | 1 Never Merried 2 Married 1 | /as Decedent Ever in U,S. med Forces? Yes 2 XNo Yes, Give ear or Dates: | 13. Was Decedent of If Yes, specify Cult | oan, Mexican, Puerto | pecify Yea or No- p Rican, etc.) | | A-American todian, k, White, etc. | | | |
| 72 ho matural dical. | 15. Decedent's Education (Specify only highest grade com | | a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin | pation during most of won | king | 16b. Kind of Bu | siness/Industry | | | |
| ed within 72 ho yglens. wer than "naturn it, the Medical. Completed | | ollege (1-4or 5+) | `life. DO NOT use retin | 9d) | | Movie 1 | Theater | | | |
| E SGTE | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | e (First, Middle, I | Maiden Surneme | 9) | | | |
| Nen Wen | George McAtee Elder | | | Rose Austin | | | | | | |
| | 19e. tnformant's Name/Relationship (Type, P | | b. Mailing Address (Stree | | | | | | | |
| / Health a / Health a / Hem 27 is other trax | Michael S. Elder- So 20a, Method of Disposition | | 9 W. Highla of Disposition (Neme of | nd Dr., | | | Y 12303 City or Town, Stete | | | |
| Pages mant of ant: If Ih any or o | 1X Burial 2 Cremetion 3 Remove 4 Donation 5 Other (Specify) | ral from State | ery, cremetory or other pla Erin Cemeter | y | | | e Grace, M | MD | | |
| Departitions of the control of the c | 21. Signature of Funeral Service Licensee | . Smith | 22. Name and Addr Mitchell-Si) 123 S. Wa | ess of Facility mith Fune shington, | ral Home | e, P.A. de Grac | | | | |
| Physician | 23a. Pany. Enter the disease, or complication shock, or heart failure. List only one can | ns that caused the deeth. Do use on each line. | not enter the mode of dy | ing, such as cardiac | or respiretory erro | est, | Approxima Interval Be Onset and | ita etween | | |
| /Medical Examiner | Immediate Cause (Finel disease or condition resulting In death) | Pneum | nie | | | | 3 week | K, | | |
| Je Je | | Chronic | consequence ot): | 01 | 1 | | 3 vies | 1.0 | | |
| physician and as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c. | | consequence of): | Puhmand | o kan | | | 9 | | |
| fing physicials as the bu | that initiated events resulting in death) Last | Due to (or as a | | | | | | | | |
| attendii 3 for use Clan/ | | | | 1 001 011 | | | | | | |
| igned by the attend be detached for us by Physician/ | Part tl. Other atgnificant conditions contribut | ing to death but not resulting | iven in Part I. | 23b. Dtd tobacco use contribute to the cause 1 ☐ Yea 2 ☑ No 3 ☐ Probably 4 ☐ | | | | | | |
| 2 should | | | | | 24a. Was a perform | | 24b. Were autopsy available prior completion of of death? | to | | |
| | | | | | 1 🗆 Ye | s 2 No | 1 🗆 Yes 2 🗆 |] No | | |
| s certificate director, pag To Be Co | 25. Was case referred to medical examiner? | al· | 10 | | th (Check only on | θ) | | | | |
| T ag | TLI Tes 250 NO | 1 USUnpatient 2 LI ER/C | dipatient 3LI DOA | | ome 5 Reside | | | | | |
| within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (| 2 Accident Investigation | (Month, Dey Year) | tnjury Wo | Yes 2□No | | | | | | |
| a affer of a Direct of in by | 4 Homicide determined 28 | Place of Injury - At home, to building, etc. (Specify) | arm, street, factory, office | | 28f. Location (St City or Town | | er or Rural Route Nur | nber, | | |
| in 24 hou he Funer pletely fill edical | (Check only 2 Medical Examiner: C | : To the best of my knowledgen the basis of examinetion and manner stated. | e, deeth occurred et the t nd/or investigation, in my | ime, dete end plece, opinion, deeth occur | end due to the carred at the time, da | ause(s) and mar ate and place, a | nner as stated. ind due to the cause(| (s) | | |
| within To the comp | 29b. Signature and title of certifier | | 29c. Licen | se number | 2 | 9d. Date aigned | (Month, Day, Year) | | | |
| . 1 |) Sacharla | | 9, – | 047813 | | JAN | 31 2000 | 31 2000 | | |
| 12 | 30. Name and address of person who completed AS HAR KAR! | | (Type, Print) Churchy, 16 | Rol Swite | 200 1 | el Air | M 5 21014 | _ | | |
| State | 31. Date filed (Month, Day, Year) | 32 Registrar's Signature | 4 loca | , | | | | | | |

Osman/ Karakash

1215

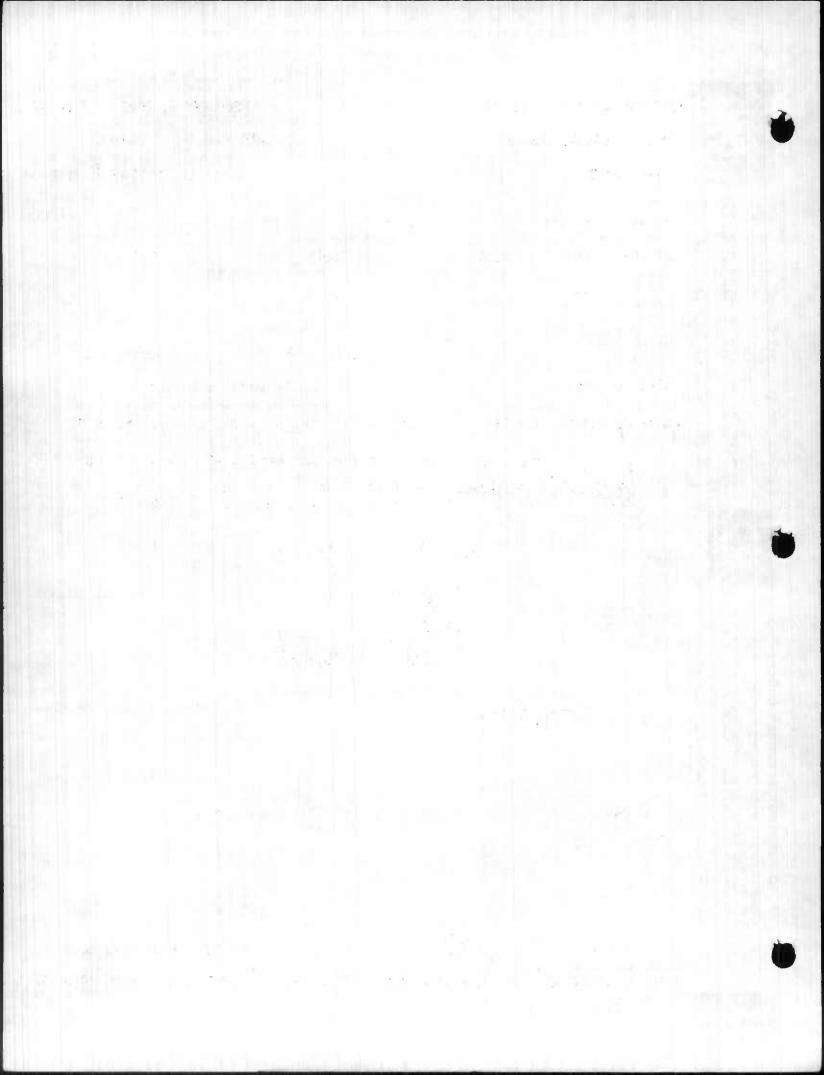
1/30/00

Elder, George

FEB 1 2000 / 1837

State of Maryland / Department of Health and Mental Hygiene 1 15 0 9 1.

| | | | | Otato or ivid | arylalla / | Certifica | | | Re | g. No. | 000 | 24 | |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------|---------------------------|-----------------------------------|--------------------------------------|--------------------|------------------------|-----------------------|--|
| | Dhualai | | 1. Decedent's Name (First, Middle, Last, | | | | | | 2. Date of Death Month | Day V | 200 | ma of Death | |
| | Physici · /Medic | | RAYMOND WOODROW | ENGLISH | | | | | FEBRUARY | 6, 2000 | 7: | 28 AM | |
| | Examin | er | 4a Facility Name (If not institution, give | | | | | 4b. City, Town, or L | | 4c. County of | | | |
| | | | CIVISTA MEDICAL CE 5. Social Sacurity Number 6. Sax | | a //m use leat hi | etherous If Line | der 1 Year | LA PLAT | | | ARLES | tete es Esseine | |
| | Funeral Director | | 5. Social Sacurity Number 6. Sax 1. XM 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 9. Birthplaca (Sacurity) 4. Month, Day, Year) April 11, 1944 Washin | | | | | | | | | | |
| | Mand Mand | | 10a. State 10b. County | | 10c. City, Tov | m or Location | | | | | 10d. Ins | Ide City Limits | |
| | Man | tor | Maryland Charles | | W | aldorf | | | | | 1□ | Yes 2 No | |
| | or 28 | irec | 10e. Street and Number | | | 10f. 2 | Zip Code | | 10 | g. Citizen of Wha | at Country? | | |
| | 23a | la | 2649 Hamilton Plac | ce, #204 | | | 2060 | | | USA | | | |
| 21215-0020 | within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show he Medical Examiner must be incidited at | by Funeral Director | 11. Marital Status 1 Never Marriad 2 🗓 Xi arried 3 Widowed 4 Divorced | 12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | es? If Yas, specify Cuban, Mexican, I Yes 2 No Specify: | | | | | | | te | |
| 5-0 | 72 ho | eted | 15. Decedent's Edu (Specify only highest grade | cation e completed) | 168 | . Decedent's Us | sual Occup | ation during most of won d) | king 1 | 6b. Kind of Busin | ness/Industry | | |
| 121 | d within 72 ho piene. r than "natur r the Medical | Completed by | Elementary/Secondary (0-12) | College (1-4or 5 | +) | | | | | | nmon+ | | |
| | 77 70 10 10 10 10 10 10 10 10 10 10 10 10 10 | | 17. Father's Name (First, Middle, Last) | | | | Locks | | ne (First, Middle, M | C Gover | nment | | |
| an | d be filed antal Hyg and other c event, | Be C | Calvin W. English | | | | | | ret E. Bu | | | | |
| Maryland | 2 should be and Mental is merked o | 2 | 19a. fnformant's Na/he/Relationship (Ty | rpe, Print) | 19 | o. Mailing Addre | ess (Street | | ral Route Number, | | ate, Zip Code) | | |
| | P = 22 | | Maria M/ English . | - Wife | 2 | 649 Ham | iltor | Place, | #204, Wal | dorf, M | D 20602 | 2 | |
| altimore, | - 1 E E | | 20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | Removal from State | 20b. Place o | of Disposition (A | lame of or other place | ce) | | Oc. Location - Cit | ty or Town, Sta | | |
| Balti | permit. Pages Department of Important: If it any injury or once. | | 21. Signature at Funeral Survice Light | 110111 | | 22. Name | and Addra | ss of Facility | Two | | | | |
| | | | 23a. Part1. Inter the disease, or complishook, or heart failure. List only or | IWN MUUI | the death. Do | not enter the m | ode of dyir | 156, Wall | or respiratory arre | 20604-0 at, | 156 Appro | eximate al Between | |
| | Physician /Medical Examiner | er | Immediate Cause (Final disease or condition resulting in death) | , M | semeli | consequence of | Info | retim | | | Onset | end Death | |
| Box 68760, | eath certificate be executed ettending physician and for use as the burial-transit | in/Medical Examiner | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | 3. | Due to (or us a consequence of): Due to (or as a consequence of): | | | | | | | | |
| | the death cer y the ettendir ached for use | Physician/M | Part if. Other significant conditions con | ntributing to death bu | it not resulting | in the underlying | g cause giv | ren in Part I. | 23b. Did tob | acco use contri | ibute to the ca | suee of death? | |
| P.0 | that the de ned by the e | Phys | ~~ | akimo | kim 0 | | | | | e 2□No 3 | ☐ Probably | 4 Unknown | |
| | sign d b | þ | 0.1 | MENIA | | | | | 24a. Was an | | 24b. Were aut | opsy findings | |
| Records, | hes to | Completed | | | | | | | 1 □ Ye | | completic of death? | on of cause | |
| Vital | | Be C | 25. Was case referred to medical | | | | | 26. Place of Dea | th (Check only one |) | | | |
| f V | 5 00 | 0 | examiner? | lospital: | nt 2 ER/O | utpatient 3 | DOA Oth | er: 4 🗆 Nursing H | ome 5 Resider | nce 6 Other | (Specify) | | |
| ion of | Attending Ph or death. ector: After th by the funeral | - Inparent all arrotherm of the second of the second of | | | | | | | | | | | |
| Division | al or Attending P s after death. I Director: After t ad in by the funera | Certification: | 3 ☐ Sulcide 6 ☐ Could not be determined | 28e. Place of Injubulding, etc. | | arm, street, fact | ory, office | | 28f. Location (Str. City or Town, | | or Rural Route | a Number, | |
| | To the Hospital or Atle within 24 hours after de To the Funeral Directo completely filled in by the | edical | 29a. Certifier (Check only one) Certifying Physical Examination (Check only one) | sician: To the best of ner: On the basis of and manner sta | examination at | | | | | | | ause(s) | |
| | To the within To the comple | Σ | 29b. Signature and title of certiliar | fempe | ms) | | 29c. Licens | 8826 (| (| d. Data signed (i | | | |
| _ | | | 30. Name and address of person who a GLENN R. EDGECOMBE | , MD, 770 | | | AVE., | #B-201, | CLINTON, | MARYLAN | ND 207 | '35 - 1629 | |
| | Sta Registr | te ar | 31. Date filed (Month, Day, Year) FEB 0 8 20 | 00 32. Registre | ar's Signature | B. 1 | bour | 2 | | | | | |

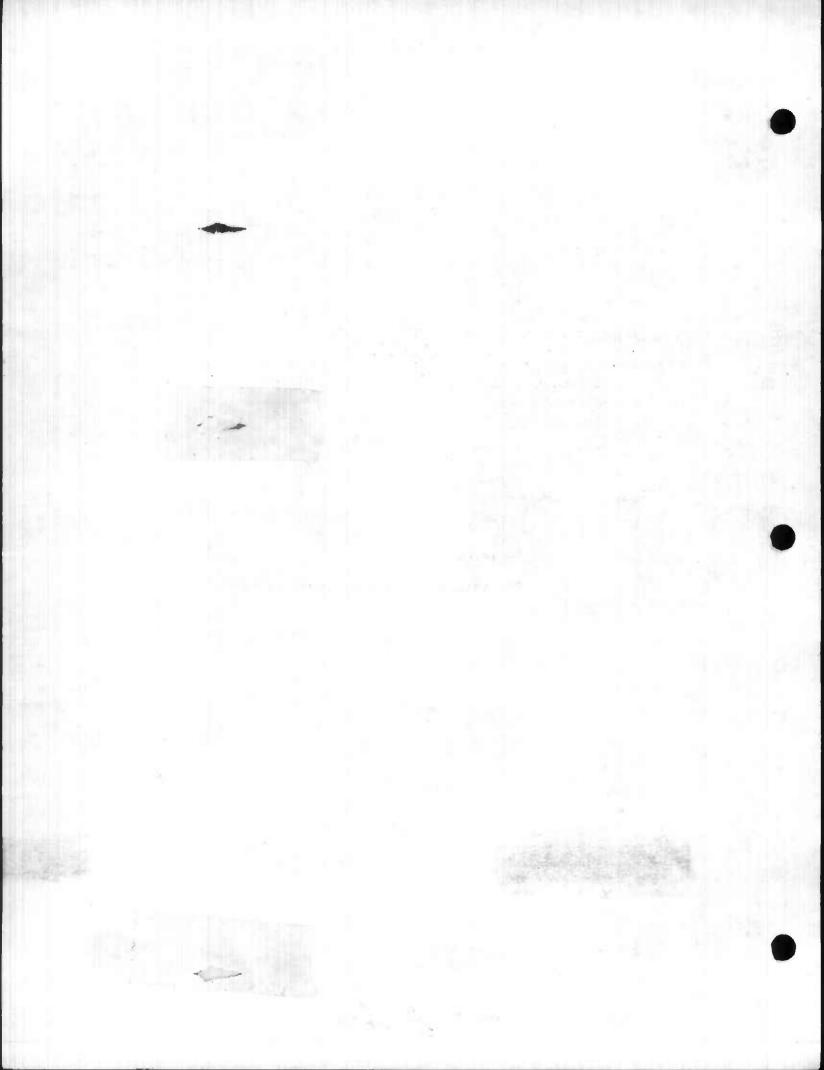


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Van Elligson **Physician** illiam 10 0247 Februar 2000 /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Baltimore Sinai If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 5, 19 9. Birthplaca (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** 10XM 2□ F Months Days Hours 218-18-7972 Yrs 76 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 1 Yes 2 No Director MD Carroll Millers 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 U.S.A. 4109 Hoffmanville Rd. 21107 items 23s Funerai 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filled within 72 hours after c Department of Heelth and Mental Hygiene. Important: If ham 27 is marked other than "natural", or hen any injury or other traumatic avent, the permits of the page 2000. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Dates: WW II 1 Never Married 2 X Married Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Shipping and
Receiving Manager 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) and Manager College (1-4or 5+) Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma E. Clinedenst John L. Elligson, Sr. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
4109 Hoffmanville Rd. Millers, MD 21107 19a. Informant's Neme/Relationship (Type, Print) Eleanor Elligson/wife Date 15, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Middletown Cemetery 2000 Freeland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc 24 Second St., New Freedom, PA 17349 Jaun 23a. Part 1. Enter the disease, or complications, or heart failure. List only one the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death **Physician** tmmediate Ceuse (Finat disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner Multiple FAILURE OKGAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be execu physician s the burial Box 68760. Physician/Medicai Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edicai Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Panding Investigation t ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 Homicide To the House of To the Funeral D completely filled is 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted. 29e. Certifier 29b. Signature and title of cartiflet 29c. License number 29d. Date signed (Month, Day, Year) 02/10/00 57717 100ma 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 6 AMOON NN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

8

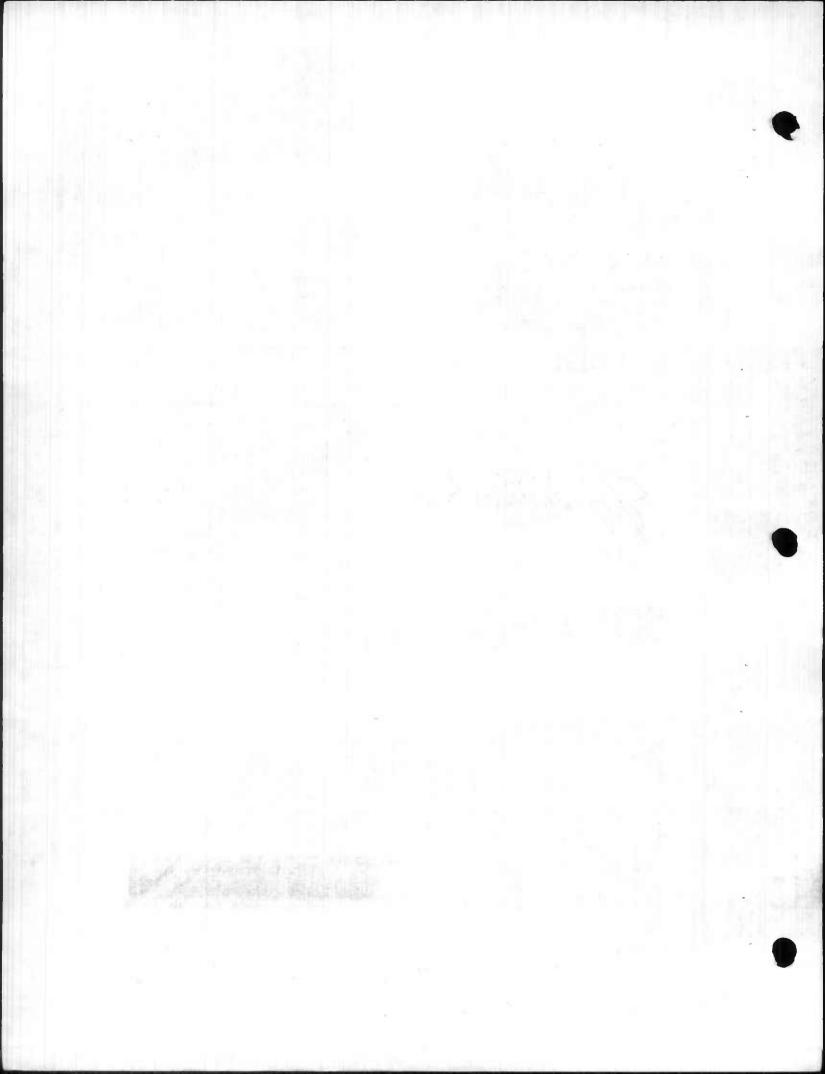


| | | State of Marylar | nd / Departi Certif | ment of Ficate of | lealth and Death | | Reg. No. | 05096 | | | |
|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|--------------------------|-----------------------------------------|----------------------|--------------------------------------------------------------------------------------|--|--|--|
| Physician /Medical | 1. Decedent's Neme (First, Middle, La Melva F. | | | | | 2. Date of De Month Febr | Day uary 6 | 3. Time of Death Year , 2000 10:25 | | | |
| Examiner | 4e Facility Name (If not institution, giv | | | | b. City, Town, o | or Location of Deat | h 4c. County | of Death | | | |
| | Greater Balt | | | | Towson | | | ltimore | | | |
| Funeral Director | 220-34-6740 | Sex 7. Age (In yrs. 1 | | Under 1 Year onths Deys | If Under 24 H Hours M | | 1918 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| p * | Usuel Residence of Decedent 10a. Stele 10b. County | 10c. Ci | ty. Town or Location | 20 | | | | 10d. Inside City Limita | | | |
| ter death with the Maryler Herra 23a or 28a-1 show for must be notified at Tuneral Director | MD Balti | | hite Ha | | | | | 1 ☐ Yes 2 ☐ No | | | |
| vith the Mar t or 28a-f all be notified Director | 10e. Streel and Number | INOT C | | Of. Zip Code | | | 10g. Citizen of \ | What Country? | | | |
| With Wild | 922 Wiseburg | Poad | ' | 2116] | | | U.S.A | | | | |
| eath na 20 | 11. Meritel Stetus | 12. Wes Decedent Ever in L | I.S. 13 Wes | | | | | | | | |
| or or or | 1 Never Merried 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: | | s, specify Cube Yes 200 No | | (Specify Yes or No erto Rican, etc.) | Specify | leck, White, etc. Lify: White | | | |
| 72 ho natur olcal | 15. Decedent's Ed | ducetion | 16a. Decedent | s Usuel Occup | ation | and the s | 16b. Kind of B | usiness/industry | | | |
| | (Specify only highest gra | College (1-4or 5+) | | | during most of w | rorking | Defense | Armament Mfg | | | |
| filed within Hyglene. Wher then ent, to the ent. | 7 | | Cafet | eria V | Vorker | | DCICIIDO | THE MICHE PILY | | | |
| Mentel H wrked off artic even | 17. Falher's Neme (First, Middle, Last) Fred S. Mill | | ame (First, Middle, er Baket | | ne) | | | | | | |
| and | 19a. Informent's Neme/Reletionship (| Type, Print) | and Number or | Rural Route Numb | Stete, Zip Code) | | | | | | |
| 2252 | Kenneth C. Enso | or/Son | 922 W: | isebur | g Rd., | White | Hall, | MD 21161 | | | |
| 2 2 2 0 | 20a. Method of Disposition 1 🕅 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specif. | Removel from Stete | Place of Disposition commetery, cremeto i Seburg | ry or other plea | | eb. 10, | | City or Town, State Hall, MD | | | |
| Department Copartment if Important: If any injury or pitca. | 21. Signeture of Foreign Service Licer 23a. Part I Unite the disease, or com shock, by heart future. List only | lartens tex | i J. | Second | tenstei | n Mortu New Fred | edom, 1 | PA 17349 | | | |
| Physician /Medical Examiner | Immediate/Cause (Final disease or condition resulting in death) | · (P) middle | coret | oral a | | CVA | 4 | Interval Between Onset and Death | | | |
| secuted in and instransit Examiner | | b. atrial | | rillat | ron | | | unknown | | | |
| cata be assecuted shysician and the bunal-transit dical Examir | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | | | |
| leath certificate be assected attending physician and for use as the burial-transit clan/Medical Examir | resulting in death) Last Due to (or es e consequence of): | | | | | | | | | | |
| death a atter ed for u | Don't I Other significant and distance | A The Alexander of the | | | | an Did | | | | | |
| ed by the detach | Part II. Other significant conditions o | ontributing to death but not res | 236. Did | ortributa to the causa of death? 3 ☐ Probably 4 ☐ Unknow | | | | | | | |
| shoul | | | | | | | an autopsy ormed? | 24b. Were autopsy tindings available prior to completion of cause of death? | | | |
| Ine law late has t page 2 s | | | | | | 10 | Yes 2000 | 1 ☐ Yes 2 ☐ No | | | |
| certificate rector, pag | 25. Was case referred to medical | | | | 26 Bloom of D | eeth (Check only o | | 10160 2010 | | | |
| | examiner? 1 Yes 2 No | Hospitel: 122hpatient 2 | ER/Outpatient 3 | Oth | er: | | | as (Casaibil | | | |
| orthis oral d | 27. Menner of Death | 28a. Date of Injury | 28b. Time of | DOA 28c. Injun | 4 🗆 I vursing | Home 5 Resi | how injury occur | | | | |
| a blactor. After the distribution: | 1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined | (Month, Day Year) | Injury | M 1 🗆 | k? Yes 2□No | | | per or Rurel Route Number, | | | |
| | 4 Normicide | building, etc. (Special special specia | (y) | | a date and pla | City or To | wn, Stete) | | | | |
| n 24 hound he Fundament file | (Check only 2 Medical Exam | niner: On the besis of examine and menner steted. | tion and/or Investi | getion, in my o | pinion, deeth oc | curred at the time, | dete and plece, | and due to the ceuse(s) | | | |
| within 2 To the comple | 29b. Signature and title of certifier | | | 29c. License | e number | | 29d. Date signe | d (Month, Day, Year) | | | |
| () | My sell | MD | | D50 | 893 | | 2.6 | | | | |
| Mo | 30. Name and address of person who | completed cause of death (Iter | n 23a) (Type, Print | 1 200 | 0 10 | 03. P> | ALTO, | MD 21204 | | | |
| State | 31. Dete filed (Month, Day, Year) | 32. Registrer's Signe | | | | | * | | | | |

DHMH 16 Rev 6/95

Ensor, Melva

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 00 05097 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JANUARY 26, Lawrence William Ellis, Jr. 2000 02:15 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 **X** M 2 ☐ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Vre 61 231-42-9325 Director July 20,1938 Maryland Usual Residence of Decedent r 25a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Maryland Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? number of 2 2310 Afton Street 20748 Funeral United States 12. Was Decedent Ever In U.S.
Armed Forces? Oct.1956

If Yes, Give Year or Dates:

12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married õ Baltimore, Maryland 21215-0020 Specify: Black à 3 Widowed 4 Divorced filed within 72 hours Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Retired/Military Enlisted Air Force years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Lawrence William Ellis. Esther Sr. am al 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trea 2005s. Annie Lee Johnson Ellis (Wife) 2310 Afton Street, Temple Hills, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 7, 2000 20a. Method of Disposition
1 Surial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility Robert G. Mason Funeral Home, Inc. 21. Signature of Fuperal Service Licegiste 1661 Good Hope Road, S.E.; Washington, D.C. 20020 m 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical COMPLICATIONS OF PANCREATIC CANCER 4 WEEKS Examiner Due to (or as a consequenca of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760, Physician/Medical Due to (or as a consequence of) use as the P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? detached 3 1 Yee 2 No 3 Probably 4 Unknown PERFORATED BOWEL of Vital Records, þ 90 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? SEPSIS has page 2 20 No 1 Tyes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA Wile. 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death.

Director: After the fur 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

JOSE GUTIERREZ, COL, 31. Date filed (Month, Day, Year)

memos

29b. Signature ay

USAF, MC 32. Registrar's Signature

VUNEZ MD

ANDREWS

29c. License number

MD D0036213

29d. Date signed (Month, Day, Year)

JANUARY 26, 2000

AIR FORCE BASE, MD 20762-6600

Registrar

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 89 MDG/ 1050 w PERIMETER RD

9000 : 2000

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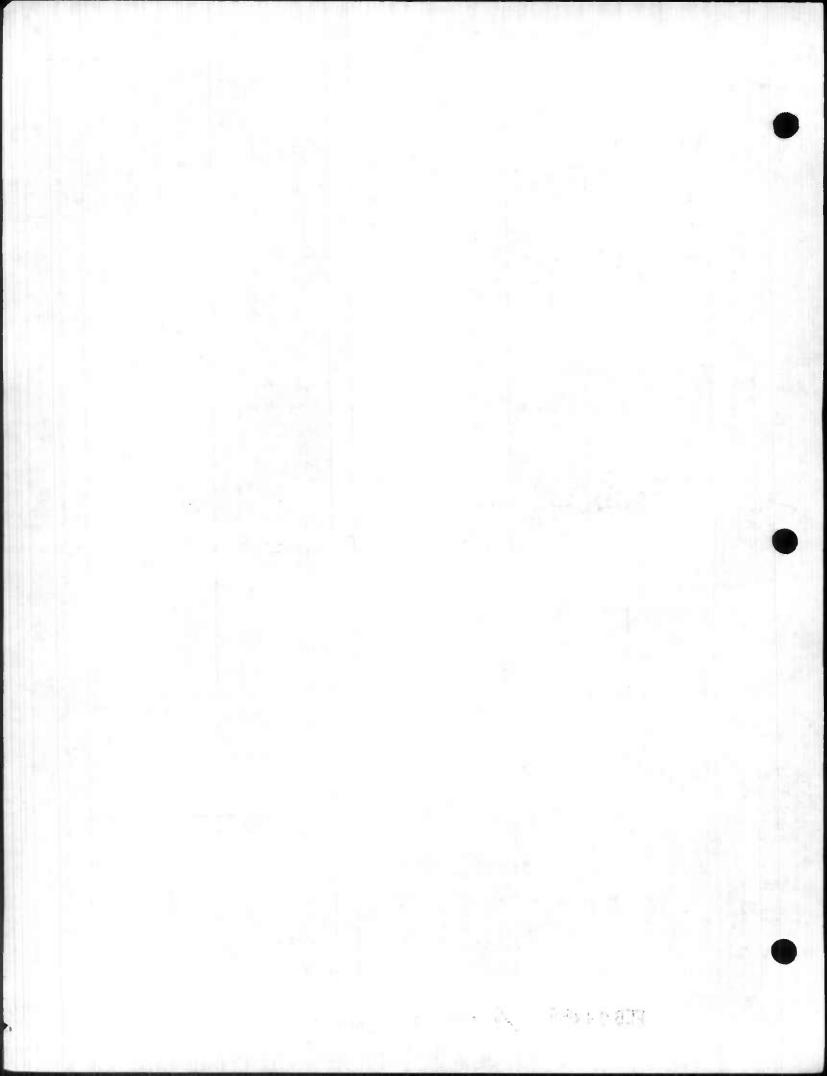
State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 4 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **EDWARDS** Month TYRONE January

4b. City, Town, or Location of Death
Silver Spring 30, 2000 8:30 AM 4a Facility Neme (If not institution, give street and number) Montgomery HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
April 29,1956 Washington, D.C. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Months 1□M 2□F 577-76-5512 43 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver SPring 1 Yes 2 No Montgomery 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 20902 USA 2610 Randolph Road 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Government Retirement Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Delores Redd Alvin Edwards 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 9610 Randolph Rd., Silver Spring, MD 20902 Marlene Ransom/sister 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Remove from Stete 4 Donation 5 Other (Specify) Chesapeake Crematory, Inc. 2/2/00 Beltsville, MD 22. Name end Address of Facility CEDAR HILL FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee ous . Frank 4111 Pennsylvania Ave., Suitland, MD 20746 1200257 231 Pm1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final 6 days MULTI ORGAN FAILURE disease or condition resulting in deeth) Due to (or as a consequence of): END STAGE LARYNGEAL CANCER Due to (or as a consequenca of): METASTATIC LIVER AND LUNG DISEASE Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1XXYee 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physician and the burat-transit

980

signed by it

page 2 s

this

After

Be

Certification: To

Medical

the death certificate be executed

Box 68760

P.O.

Records, The law requires

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

MD

Director

Funeral

à

Completed

88

Funeral

Director

28a-f

8

Berns 23a

8

"natural".

Hygiene.

permit. Pages 1 and 2 should be filled w Department of Health and Mental Physion Important: if liven 27 is marked other tha any injury or other traumatic

the Mandand

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical by Completed

(Check only one)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 25No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Neturai 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours after death.
To the Funeral Director: Af Within 2 To the

Hospital

29b. Signeture and title of certifier V Therell Andling

MID

29c. License number 051158 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vatti J. Anthony, M.D. 2901 Research Blvd. #102 Rockville, MD 20850 31. Date filed (Month, Day, Year)

State Registrar

FEB 0 3 2000





1881 8 9 679

10f. Zip Code

20814

7. Age (In yrs. last birthday)

84

12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Yre.

10c. City, Town or Location

BETHESDA

AZOTEMIA

DEHYDRATION

Due to (or as a consequence of):

Due to (or as a consequence of):

State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 Certificate of Death

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) VIRGINIA BELLE EVERETT

Month

3. Time of Death

4a. Facility Name (If not institution, give street and number)

10 M 2 F

JANUARY 4b. City. Town, or Location of Death

8:30PM

Funeral

Director

the Maryland ? is marked other than "naturel", or items 23a or 28a-f sho treumetic event, the Medical Examinar must be notified at death

other t

Baltimore, Maryland 21215-0020

physician end the buriel-transi esn signed by t director.

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: efter deeth. Director: Aft 24 hours e To the Vithin 2

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "naturel", or ite permit. Pages Department of Important: If It any injury or c **Physician** /Medical Examiner

MARINER NURSING HOME 5. Social Sacurity Number 212-68-5415 Usuel Residence of Decedent 10a. Stete 10b. County Directo MARYLAND MONTGOMERY 10e. Street and Number 10014 EDWARD AVENUE Funeral 1 Never Married 2 Married þ 3 Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 17. Father's Name (First, Middle, Last) CROZIER ROSS 19a. informant's Name/Relationship (Type, Print) WILLIAM EVERETT-SON 20a. Method of Disposition 1 Burlai 2 □ Cramation 3 □ Removal from State 4 Donation 5 Other (Specify) Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai by Completed 25. Wes case referred to medical examiner? Be

1 Yes 2 No 27. Manner of Deeth 1 Natural 2 Accident 3 Sulcida 4 Homicide

Medicai State Registrar

Certification:

29a. Certifier

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMEL

ANEMA

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

5 Pending investigation 6 Could not be determined

15 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifie

29c. Licanse number

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

30692

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) GOOS, DS MANNAT

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

GABRIEL A. BERREBI 31. Date flied (Month, Day, Yeer) FEB 0 2 2000

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 16 Rev 6/95

2. Dala of Death 25,

2000 4c. County of Death MONTGOMERY

BETHESDA

If Under 1 Yaar

| Min. | No. 9. Birthpiace (State or Foreign

Yaar

10d. Inside City Limits 1 Yes 2 No

10g. Citizen of What Country? UNITED STATES

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Raca - American Indian, Black, Whita, atc. Specify: WHITE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

HOMEMAKER OWN HOME

18. Mother's Neme (First, Middle, Meiden Sumeme) FANNIE P. HETHERINGTON

19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

10014 EDWARD AVE. BETHESDA, MARYLAND

20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FORT LINCOLN CEMETERY

1/28/2000 BRENTWOOD, MARYLAND

22. Nama and Addrass of Facility

FORT LINCOLN FUNERAL HOME

23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approximate Approximate Approximate Shock, or heart feilure. List only one cause on each line.

Interval Between Onsal and Death

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 dunknown

24b. Were autopsy findings available prior to complation of cause of death? 24e. Wes en autopsy performed?

2 X No 1 Yes 2 No

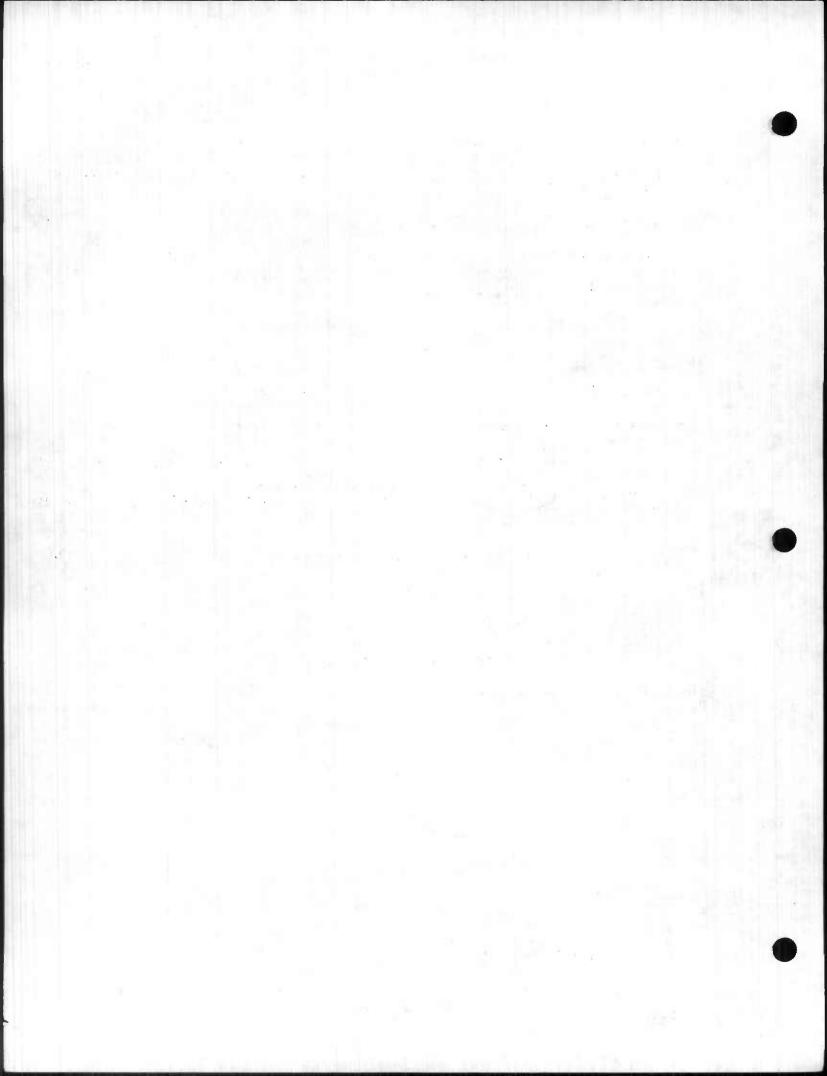
15225 SHADY GROVE RD. ROCKVILLE, MARYLAND

00077 4 835

State of Maryland / Department of Health and Mental Hygiene 00 05 101

| Decedent's Name (First, | A 42-4-4- * | -4) | - | Ocitin | TOUTO OF | Death | 100. 15 | Reg. No. | |
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| | , Middle, Las | st) | | | | | 2. Date of De Month | eath Day | Year 3. Time of Dea |
| Eleanora Ma | | | | | | | Februa | - | 10:11 |
| 4a Facility Name (If not ins | stitution, give | street and number | 7) | | | 4b. City, Town, o | r Location of Deal | h 4c. County | of Death |
| Union Hospi | tal o | f Cecil C | County | y | | Elkton | | Cecil | |
| 5. Social Security Number | 6. S | | ge (In yrs. | Me | Under 1 Year onths Days | | | th av. Year) | Birthplace (State or Fo Country) |
| 171-24-4207 | | OM 2∏F | 70 | Yrs. | | | January | 8,1930 | Pennsylvania |
| Usual Residence of Deced | | | 10- 0 | Town and annot | | | | | 4041 11 01 11 |
| | County | | 100. CR | ty, Town or Location | 9.11 | | | | 10d. Inside City Li |
| Maryland Cec | il | | Ris | sing Sun | | | | | 1 ☐ Yes 2 🕅 |
| Maryland Cec | | | | 1 | Of. Zip Code | | | 10g. Citizen of \ | What Country? |
| 23 Washingto | n Sch | oolhouse | Road | 2 | 21911 | | | United | States |
| 11. Marital Status | | 12. Was Deceden | t Ever in U | ,S. 13. Was | Decedent of I | Hispanic Origin? | Specify Yes or Norto Rican, etc.) | - 14. Rac | ce - American Indian, ck, White, etc. |
| 1 Never Married 20 | Marned X | 1 ☐ Yes 2 ☑ | No | | | | nto moan, otc.) | | |
| 3 ☐ Widowed 4 ☐ Div | becrov | If Yes, Give Year or Dates | : | 10 | Yes 2∏ No | <i>эреспу</i> : | | Specify | White |
| | cedent's Ed | | | 16a. Decedent | s Usuel Occu | pation | -4.5 | 16b. Kind of Br | usiness/Industry |
| 15. De (Specify only Elementary/Secondary (0 12 | - | College (1-4or 5+) | | life. DO I | VOT use retire | during most of w | onking | | |
| 12 | 0-12) | College (1-40) | 34) | Seamst | ress | | | Clothin | Q |
| 17. Father's Name (First, M | fiddle, Last) | | | | | 18. Mother's N | ame (First, Middle | | M |
| Orden Brest | | | | | | Messa | h /1 | | 40.5 |
| Orion Presto | | Time Original | | 10h Maii A | ddenen Mari | | et (unkno | | Stete, Zip Code) |
| | | | | | | | | | |
| Roxanne Raci | | Daughter | 201 5 | 2777 B: Place of Dispositio | | lghway, | | | land 21901 |
| 20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem | | Removel from State | | cemetery, cremeto | ry or other pla | ce) F | ebruary | 20c. Location - | City or Town, Stete |
| 4 □Donation 5 □Ot | her (Specify |) | | enezer C | emeter | | | Rising : | Sun, Maryland |
| 21. Signature of Funeral Si | ervice Liberi | 500 | | 22. Ne | me and Addre | ess of Fecility | | | |
| 11/1/12 | le | | | | | neral Ho | | | |
| 23a, Part1, Enter the disea | | | - d ab - d - ab | 127 | South | Main St | reet, No | rth East | , Maryland 21 |
| 23a. Part1. Enter the disea shock, or heart failure | List only | one cause on each | line. | in. Do not enter th | e mode or dy | rig, such es caro | ac or respiretory a | irrest, | Interval Between |
| | | 0 | | | | . 0 | | | Oriset and Dear |
| Immediate Cause (Final disease or condition | | . Is che | mire | Cendu | muca | ewhy | | | 3925 |
| resulting in death) | | . Ischer | Due to (d | or as e consequen | ce of): | | | | |
| | | almin | alize | 0 0100 | . 0 | 1 1 1 | | | 1. |
| | | | - VUM | OV I MAI | ADCCY | V CKCAN | | | : "years |
| Sequentially list conditions | | D | Due to (c | or as a consequen | 105CX | wons | | | "years |
| Sequentially list conditions if any, leading to immediate cause. Enter Underlying | | idu D | Due to (c | or as a consequen | 105CL co of): | W-0817 | | | "years |
| Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events) | • { | e ity p | ERTS | MSION | | WONS | | | "years |
| Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | c. ity p | Due to (o | STOW or as a consequence | ce of): | wons | | | "years |
| Cause (Disease or injury that initiated events resulting in death) Last | • { | . ity po | Due to (o | MSION | ce of): | me | | | "yeans |
| Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | • { | . Ity p | Due to (o | STOW or as a consequence | ce of): | me | | | "yeans |
| Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant or | l | | Due to (o | ension or as a consequence Reval | co on: Feel | | 23b. Did | tobacco use co | ntribute to the cause of de |
| resulting in death) Last | l | | Due to (o | ension or as a consequence Reval | co on: Feel | | | tobecco use co Yes 2□ No | entribute to the cause of dis |
| resulting in death) Last | l | | Due to (o | ension or as a consequence Reval | co on: Feel | | | | |
| resulting in death) Last | l | | Due to (o | ension or as a consequence Reval | co on: Feel | | 1 - 24a. Wes | Yes 2□ No | 3 Probably 42 tink 24b. Were autopsy finding available prior to |
| resulting in death) Last | l | | Due to (o | ension or as a consequence Reval | co on: Feel | | 1 - 24a. Wes | Yes 2 No | 3 Probably 42-Onk 24b. Were autopsy findir |
| resulting in death) Last | l | | Due to (o | ension or as a consequence Reval | co on: Feel | | 24a. Wes | Yes 2 No | 3 Probably 4 to the 24b. Were autopsy finding available prior to completion of cause of death? |
| Part II. Other significant co | onditions co | | Due to (o | ension or as a consequence Reval | co on: Feel | ven in Part t. | 24a. Wes | Yes 2□No an autopsy ormed? Yes 2□No | 3 Probably 42 tink 24b. Were autopsy finding available prior to |
| Part II. Other significant co | onditions co | ontributing to death | Due to (o | or as a consequence demail and a consequence d | ce of): | ven in Part t. 26. Place of D | 24a. Wesperi | Yes 2 No s an autopsy ormed? Yes 2 No one) | 3 Probably 42 Onk 24b. Were autopsy findir available prior to completion of cause of death? 1 Yas 2 No |
| Part II. Other significant co | onditions co | ontributing to death | Due to (o Ne but not res | or as a consequence of the conse | ce of): Cull tying cause gi | ven in Part t. 26. Place of D her: 4□ Nursing | 24a. Wei perli | Yes 2 No an autopsy primed? Yes 2 No one) | 3 Probably 42 Onk 24b. Were autopsy findia available prior to completion of cause of death? 1 Yes 2 No ner (Specify) |
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 26,2000 January 1:25AM Vincent M. Flynn 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Heritage Harbour Health&Rehab. CenterAnnapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Deys 1₩ 2□F Months Hours 181-20-4285 Yrs. Jan.21,1929 Phila. Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits Marvland Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2624 Quiet Water Cove 21401 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Driver Trucking 18 Mother's Name (First Middle Maiden Surgame) 17. Fether's Neme (First, Middle, Last) Unknown Unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Flynn/Son 23236 Oak Hill Lane California, Md. 20619 20b. Place of Disposition (Name of commetery, cramatory or other place)
Metropolitan Crematory 1/26/2000 Alexandria, VA. 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home, P.A. 2973 Solomons Is. Road Edgewater, Md. also 21037 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, theert feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): that initiated events resulting in deeth) Last Due to (or as e consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 ENetural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

The lew requires that the death certificete be executed P.O. Box 68760. Division of Vital Records.

physician ar 93 980 for signed by the a been significant certificete has b at or Attending Physician: The safter death.

I Director: After this certificet of in by the funeral director, pa n 24 hours after dea ne Funeral Director pletely filled in by th Hospital To the I within 2.

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show yorly injury or other treumatic event, the Wedest Evantmer must be notified at ends.

Physician

/Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

edicai

29a, Certifier

(Check only one)

30. Name and addg

29b. Signature and title of

Baltimore, Maryland 21215-0020

State Registrar

a Day, Year)

person who completed cause of death (Item 23a) (Type, Print) avaKoli

32. Registrer's Signeture

29c. License number

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and manner lated.

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and menner as stated.

29d. Date signed (Month, Day, Year)

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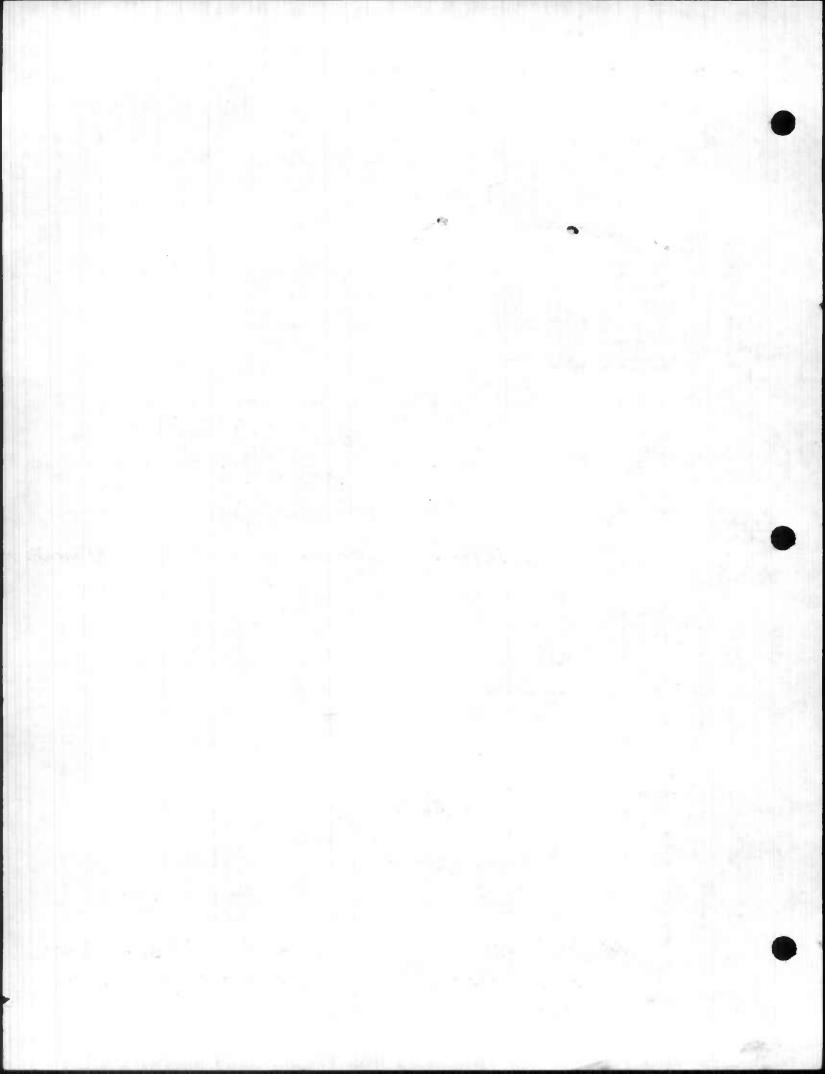
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Amended Item#2 perPhyG780 2/25/2000 EW Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** 11:46pm FCD.4 2000 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland lintor If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. July 28 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Months , 1930 579-36-1124 M 20 F 69 Washington DC Director Usual Rasidence of Decedent the Maryand 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director 28a-f MD Charles Waldorf 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 23a or 3613 Funeral Lisa Wav 20601 USA 12. Was Decedent Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian 11. Marital Status Biack, White, atc. 72 hours after 1 Never Married 2 Married Was 2□NoKorean 1 ☐ Yas 2 No Specify: Specify: White Baltimore, Maryland 21215-0020 8 à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Salesman Cars 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Walter H. Fluharty, Sr. Ada M. McKay Fluharty 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) tor other traur Helen Fluharty/Wife 3613 Lisa Way Waldorf,MD 20601 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition

1△ Buriai 2 □ Cramation 3 □ Removal from State 20c. Location - City or Town, Stata Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Mary's Cemetery 2/8/00 Bryantown, Maryland 22. Nama and Addrass of Facili 21. Signatura of Funaral Service Licenses AREHART-ECHOLS FUNERAL HOME, P.A. m00945 P.O. BOX 567 LA PLATA, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** /Medical Immediata Causa (Final 4 months disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner **burial-transit** The law requires that the death certificate be executed Sequentially list conditions, if any, taading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in daath) Last Dua to (or as a consequence of): pug Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): signed by the at 1 be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2□ No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to phoods complation of cause of death? 2□ No certificate Hospital or Attanding Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3□ DOA this Manper of Death 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? After Naturai 5 Panding invastigation 1 Yas 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) completely filled in by 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifian (Check only one) Within 2 To the ŝ 29b. Signatura and titia of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) WALDORF MD 31. Date filed (Month, Day, 32. Registrar's Signatura State 0 7 2000

Registrar

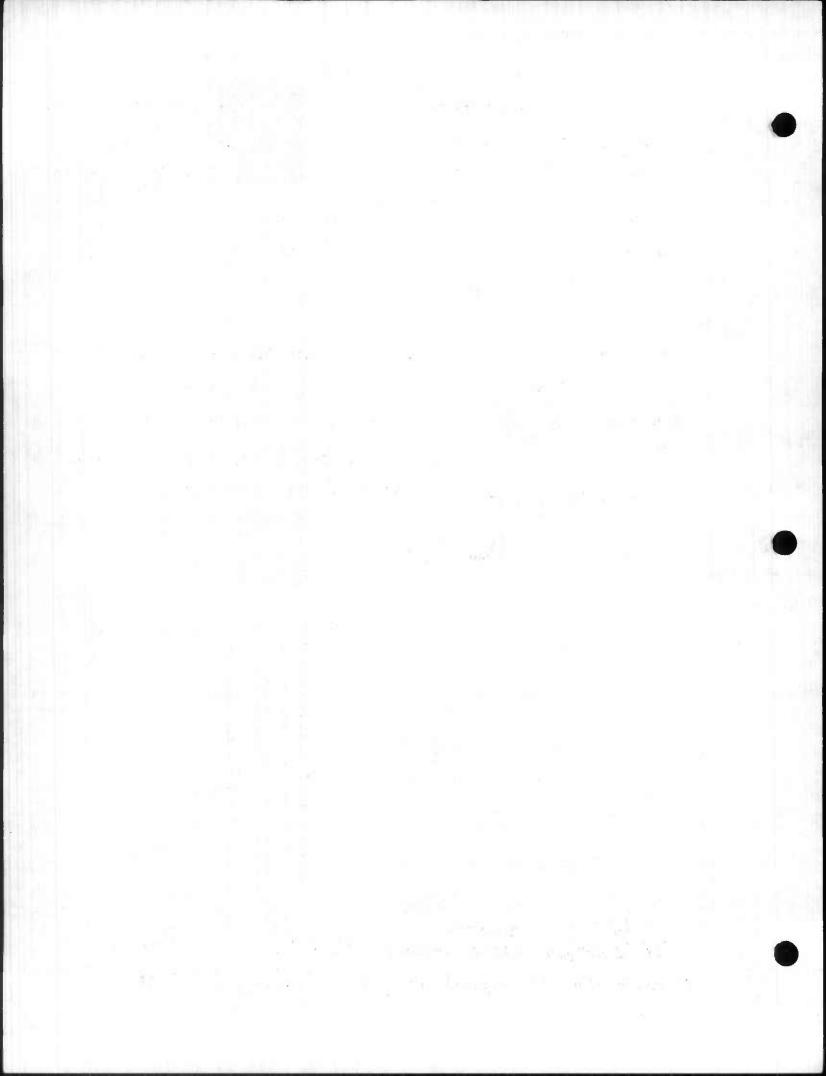
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 0 5 1 01.

| | | | | State of W | arylanc | | tificate of | Death | ivieritai r iy | Reg. No. |) () | 5104 | |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------|--|
| | Physic | an | Decedent's Name (First, Middle, Le | * | | | | | 2. Date of De Month | | Year | 3. Time of Death | |
| J | /Medi | cal | 4a. Fecility Neme (If not Institution, gh | etty Lou G | | | | 4b. City, Town, or | Januar | | 000 | 9:20 am | |
| 4 | Exami | ner | | Craigtown | | | | | | h 4c. County | _ | | |
| | Funeral Director | | 5. Social Security Number 6. 8 215-34-5144 | | | st birthday) Yrs. | If Under 1 Year Months Days | | 8. Date of Bi | th (Year) 939 | Ceci 9. Birthpi Count Ma | iace (State or Foreign try) aryland | |
| | and | | Usuai Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Loc | ation | | | | 10 | Od. Inside City Limits | |
| | Mary | tor | Maryland Cec | i1 | 3 | | P | ort Depos | sit | | | 1 ☐ Yes 2XXVo | |
| | or 284 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of 1 | What Count | try? | |
| | ath w | rail | 767 Craigtown Ro | | | | | 21904 | | | ١. | | |
| 020 | within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Merried 2 🕅 Merried 3 Widowed 4 Divorced | Armed Forces? | Armed Forces? 1 Yes 200 No If Yes, Give 1 Yes, | | | Decedent of Hispanic Origin? (Specify Yes or Ns, specify Cuban, Mexican, Puerto Rican, etc.) Yes XXXNo Specify: | | | No- 14. Rece - American Indian, Black, White, etc. Specify: White | | |
| 5-0 | 72 ho | Completed | 15. Decedent's E (Specify only highest gro | ducation ade completed) | tion 16a. Decedent's Usompleted) (Give kind of life. DO NOT | | | pation during most of wo | rking | 18b. Kind of B | | ustry | |
| 121 | s within 72 ho liene. r then "netur | mpl | Elemantary/Secondary (0-12) Twelve Years | ed) | The Cut er/Operator Port De | | | , Maryland | | | | | |
| Maryland 21215-0020 | 등 수 로 두 | Be Co | 17. Father'a Name (First, Middle, Last |) | me (First, Middle | | - | , riary rand | | | | | |
| | | ToB | Ne | lson Lee H | Virgie 1 | Mae Walt | on | | | | | | |
| | d 2 should th and Mer 7 is marks traumatic | | 19a. intormant'a Name/Ralationship (Andrew Gresko (Hi | | n Road, P | | | | | | | | |
| | Healt Healt Hem 2 | | 20a. Method of Disposition | usband) | 20b. Pla | ca of Dispos | ition (Name of | | Date | 20c. Location | - | | |
| Baltimore, | Pages nent of the ant: If its | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | | i | - | ingham (| Cemetery | 2/2/00 | Colora, | | | |
| | permit. Pages Department of Important: If it any injury or once. | | 21. Signeture of Funeral Service Lice | 1600 | | 22. | Name end Addre | ess of Facility | | n Funeral Home | | | |
| • | 805 5 8 | | Thomas M. | tatiers | S. xa | - | | e, Maryla | | neral но 03-0766 | me | | |
| | Physician /Medical Examiner | her | 23a. Pert1. Enter the disease, or com ahock, or haart failure. List only immediata Cause (Final disease or condition resulting in deeth) | · Cole | an Co | INCEV as a consequ | | | | | ١ | Interval Between Onset and Death | |
| , | cate be asscuted physician and s the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying | b | Dua to (or | as a consequ | ienca ot): | | | | 1 | | |
| K 68760, | E 0 6 | Medical | Cause (Disease or injury that initiated events rasulting in death) Last | d. | Due to (or as e consequence ot): | | | | | | | | |
| Вох | death cert | clany | | | | | | | | | | | |
| 0 | 0 0 0 | Physician/N | Part it. Other significant conditions of | ontributing to death b | derlying cause gi | | | | the cause of death? | | | | |
| ď. | es that igned t | by P | | | | | | | * | Yes 200No | 3 Prob | eably 4 Unknown | |
| of Vital Records, | aw requir is been s 2 should | Completed | | | | | | | 24e. Was | an autopsy ormed? | ava | ore autopsy tindings hilable prior to impletion of cause death? | |
| al B | The ate | | | | | | | | 10 | Yes 2XXVo | 1□ | Yas 2□ No | |
| Ž | Physician: The this certificate and director, page | o Be | 25. Wes case reterred to medical examiner? 1 ☐ Yes ②∑No | Hospital: | 005 | 200 | oct son Ot | hor: | ath (Check only | | 40. 4 | | |
| | g Phys er this eral di | n: To | 27. Manner of Death | 1 ☐ inpatie | iry 2 | R/Outpatient 28b. Time of | 3□ DOA 28c. inju | 4 LI Nursing F | lome 5 ☑ Resi 28d. Describe | how injury occur | |) | |
| Sior | Attending or death. | atio | 2 Accident 5 Panding investigatio | | y rear) | injury | | Yes 2 No | | | | | |
| Division | 子子子 | Certification: | 3 ☐ Suicide 6 ☐ Could not be datarmined | building, et | c. (Specify) | | et, tactory, office | | City or To | | | | |
| | Hospital 24 hours Funeral (etely filled | edical | 29a. Cartifier XXX Certifying Ph | ysician: To the best on niner: On the basis of and mannar sto | examination | edge, death on and/or inve | occurred at tha ti estigation, in my | ma, date and place opinion, daath occu | a, and dua to tha urred at tha tima, | causa(s) and ma data and place, | enner as sta end due to | ated. the cause(s) | |
| | To the within 2 To the comple | M | 296. Signature and the of certifier | DIREC | | | 29c. Licen | | | 29d. Date signe | d (Month, E | Day, Year) | |
| | | | vanleerchouse | a MEDICA | , | 01064 | 02 | 3675 | | 2-1. | | | |
| | 10 | | 30. Name and address of person who | completed cause of d | leath (Item 2 | 23a) (Type, P | rint) . | Be Wru | one, UND | 2128 | 7 | | |
| | Sta Registr | OSHEGIN) | 31. Date filed (Month, Day, Year) FEB 3 200 | 22. Registr | ar's Signatu | re 4 | loo d | / | `\ | | • | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month **Physician** ERNEST GUNNING HENRY February 08, 2000 9:04AM /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Id Plata

If Under 24 Hrs. 8. Date of Birth
Houra Min. (Month, Dey, Year) Civista Medical Center Charles If Under 1 Year 5. Sociel Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Director 044-18-0813 September 29,1923 CT Usuel Residence of Decedent 10a. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits a 23s or 28s-f show must be notified at 1 Yes 2 No Directo Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6305 Sleepy Hollow Road Nerns 23s 20646 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-il Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 X Yes 2 No 1943 If Yes, Give Yeer or Detes: - 1945 1 Never Merried 2 Married 8 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 1945 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Sales Manager Food/Produce 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be and Mental Harold Gunning Sophie Kroll Gunning 19e. Informent'a Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Kevin Gunning/Son 6305 Sleepy Hollow Rd. La Plata, MD. 20646 mportant: If Item 27 Baltimore, 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Pages 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2/14/00 Cheltenham, MD. Maryland Veterans 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility AREHART-ECHOLS FUNERAL HOME, P.A. M00945 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dynd, such as partial of the property of the proximate shock, or heart fellure. List only one ceuse on each line. Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical MYOCARDIAL Examiner ARTERY DISEASE Examiner the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, laeding to immadiate causa. Enter Underlying Ceuse (Disease or injury that initieted events rasulting in death) Last Due to (or es e consequence of): Type II

Due to(for es a consequence of): Box 68760. Physician/Medical 88 44PERTENSION P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24a. Wes an autopsy performed? Completed 24b. Wara autopsy lindings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical axaminer? Be 26. Piace of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) To 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? edical Certification: Affer 1 Natural
2 Accident Division or Attending 5 Pending investigation 1 Yes 2 No death. Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Plece of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by 4 \(\text{Homicida} \) Certifying Physician: To the best of my knowledga, deeth occurred at the time, data and place, and due to the cause(s) and menner as stated.

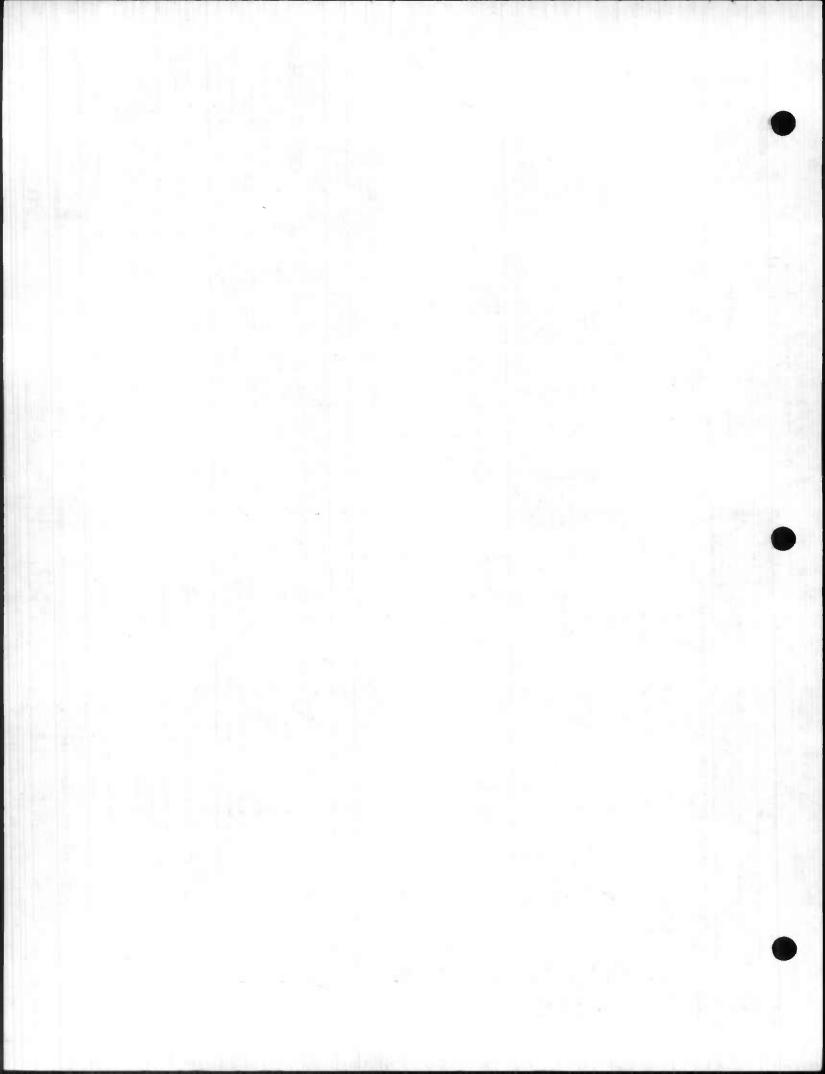
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, daath occurred et the time, dete and place, and due to the cause(s) and menner ateted. 29a. Certifier (Check only 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D-47849 30. Name and eddress of person who completed causa ol daeth (item 23a) (Type, Print) Monika G. Lee, MD 12070 Old Line Centre #100, Waldorf, Maryland 20602

Registrar **DHMH 16 Ray 6/95**

State

31. Dete Illed (Month, Dey, Year) FEB 0 9 2000

32. Registrer'a Signeture

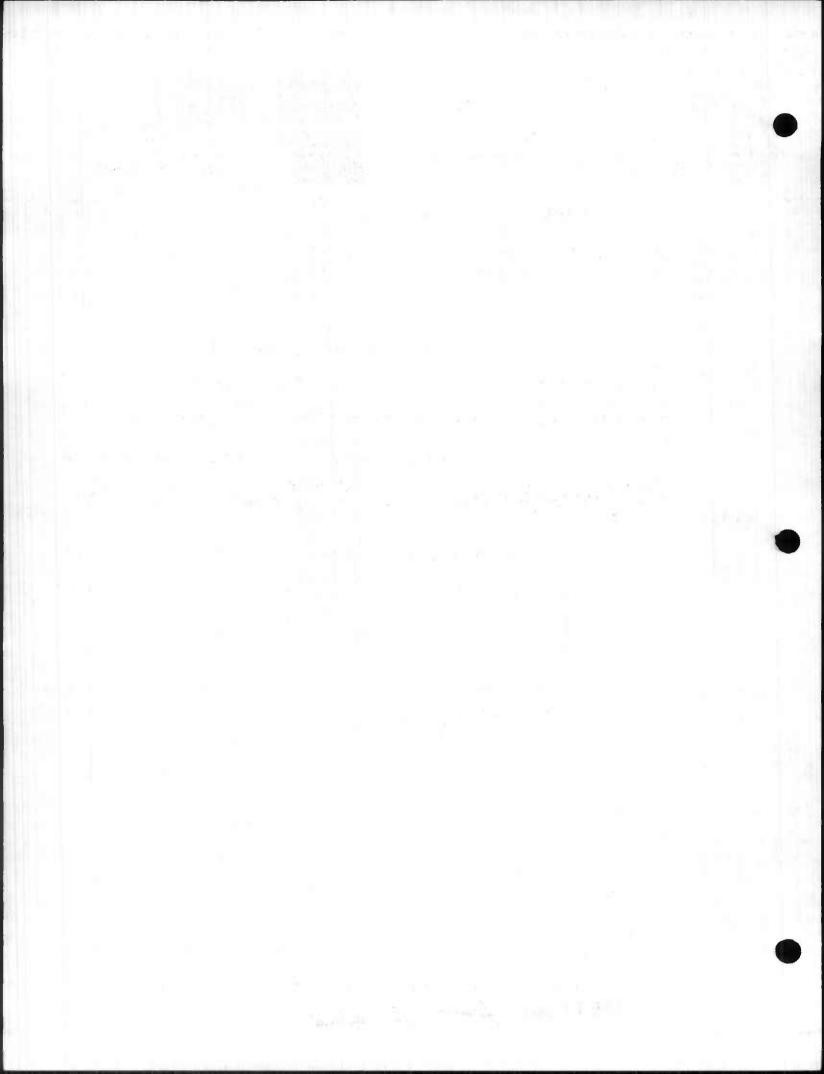


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State of Maryland / Department of Health and Mental Hygiene 0.5.106

| | | 1 Decadant's Nan | ne (First, Middle, Li | actl | | Ce | ertificat | e of | Death | 2. Data of D | Reg. No. | | Time of D | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------|---------------------------------|-------------------------------------|-----------------------------|----------------|------------------------------------------|------------------------------------------|----------------------------------------------------------------------|----------------------------------------------|-----------------------------|--|--|
| Physic /Medi | | | | klin Grave | s, S | r. | | | | Month | | | 7/ DM | | |
| Exami | | | | ve street and number) | | | | | 4b. City, Town, o | r Location of Dea | ath 4c. Count | y of Death | 34 PM | | |
| | | | ary's Hos | · | | | | | Leonard | | | Mary's | | | |
| Funeral Director | | 5. Social Security N 457-70-40 Usual Residence of | 611 | Sex 7. Ag | je (In yrs. | last birthdaj Yrs. | Months | 1 Year Days | | n. 8. Date of B (Month, L Novembe | 8. Date of Birth (Month, Day, Year) November 9, 1939 Mary land | | | | |
| ytand | | 10a. State | 10b. County | | 10c. Ci | ty, Town or I | Location | | | | | | nside City Limits | | |
| Mar e | ctor | Maryland | St. Mary | S | Me | echanic | sville | | | | | 1 | ☐ Yes 2☐ No | | |
| or 2 | Dire | 10e. Street and Nu | | | | | | Code | • | | 10g. Citizen of | | | | |
| 23g | erai | 20088 La | urel Gro | VE COURT | Fuor in 1 | 20659 | | | | | U.S.A. | | American Indian | | |
| permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show ship fajury or other traumatic event, the Medical Examinal must be notified at ance. | by Fun | | ried 2 Merried | Armed Forces? 1 Yes 2 If Yes, Give Yaar or Dates: | | If Yes, specify Cuban, Mexican, Pua | | | | (Specify Yas or Narto Rican, etc.) | Specif | e-American Indian, ck, White, etc. White | | | |
| | etec | (Spe | 15. Decedent's E cify only highest gr | ducation ade completed) | | 16e. Dec | edent's Usu e kind of wo | ai Occup | petion during most of w | rorking | 16b. Kind of B | usiness/Industr | у | | |
| | Idmo | Elementery/Second 12th | | College (1-4or | 5+) | 1 | | | | | U.S. Go | vernment | | | |
| | numetic event, the Medical Examiner must be notified To Be Completed by Funeral Director | 17. Fathar's Name | (First, Middle, Las | ") | | Nerrig | Cracioi | I/AII | T | | le, Maiden Sumar | | | | |
| | | Richard | d Harold | Graves | | | | | | t Lucy I | | | | | |
| | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run | | | | | | | | | | le) | | | |
| em 27 l | | | - | ves, Jr. S | | | | | | | hurch, V | | | | |
| or of | | | Cramation 3 | Removal from State | | Plece of Disponentery, cri | | | - | Date | | - City or Town, | | | |
| njury | | 4 Donation 5 Other (Spacify) Our Lady's Cemetery 2/11/2000 Leonardto | | | | | | | | | | | | | |
| eny li | | 22. Nama and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P. O. Poy 270 Leonandtown Manufand 2065 0 | | | | | | | | | | | | | |
| | | P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | | | | | | | | |
| sician | | 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate their affailure. List only one cause on each line. Approximate their affailure. List only one cause on each line. | | | | | | | | | | | | | |
| ledical | er o | Immediate Cause disease or condition | (Final | Her D | AY | 2 4 4 4 (| 4 | | | | | - | 41 | | |
| ıminer | | Immediate Cause (Final disease or condition resulting in death) a. Hypoxamia Due to (or as a consequence of): b. Metartative Sarcoma 4 mo. | | | | | | | | | | | | | |
| sit | | o metastatic sarcomas 4 mo | | | | | | | | | | | no. | | |
| al-trar | Exar | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): | | | | | | | | | | | | | |
| ig physician and as the burial-transit | cail | Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): | | | | | | | | | | | | | |
| as th | Medi | resolung in deeth) cast | | | | | | | | | | | | | |
| tandir or use | Physician/M | d | | | | | | | | | | | | | |
| the at hed fo | sici | Part ii. Other signit | | contributing to death b | | | | ause gh | ven in Part i. | 23b. Die | d tobacco use co | entribute to the | cause of death? | | |
| detac | F. | Dialu | Les me | lletur - | tur | . 2 | | | | 10 | Yes 2 No | 3 Probably | 4 Unknown | | |
| been signed by the attandir should be detached for use | d by | | | · · | | | | | | 24a Wa | s an autopsy | 24h Were a | utopsy findings | | |
| shou | Completed | | | | | | | | | | formed? | availeb | e prior to tion of causa | | |
| certificata has rector, page 2 | ошо | | | | | | | | | 10 | Yes 2 No | of death | 2 □ No | | |
| rtmcar stor, p | Bec | 25. Was case refer | rred to medical | | | | | _ | 26. Place of D | eeth (Check only | | | 20110 | | |
| o sin | To | examiner? | €No | Hospitel: | ent 2 | ER/Outpation | ent 3 DC | Ott Ott | hor | | sidence 8 Oth | ner (Specify) | | | |
| Director: Aftar this d in by the funeral di | | 27. Menner of Deat | 5 Pending | 28a. Date of Inju (Month, Da | ry y Year) | 28b. Time injury | | 8c. Inju Wo | | 28d. Describe | how injury occur | rred | | | |
| tor: A | Certification: | 2 ☐ Accident 3 ☐ Suicide | investigatio | 00- 01 | un. As h | | M | | Yes 2 No | 204 Legation | (Street and Num) | has as Round Ca | sto Atumbas | | |
| Direc in by | ertif | 4 Homicide | determined | 28e. Plece of inj building, et | ury - At n c. <i>(Specil</i> | oma, term, s | treet, fector | , office | | | (Street and Numi own, State) | oer or Hural Hol | ne Num <i>ber</i> , | | |
| 5 60 00 | edicai C | 29a. Certifier (Check only one) | Certifying Pt | nyaicien: To the best of miner: On the basis of and manner sto | axamina | wledge, dea tion and/or i | th occurred nvestigation | et the ti | me, date and place opinion, death occ | ce, and due to the curred at the time | e ceuse(s) end ma e, date and place, | anner es stated end due to the | cause(s) | | |
| withir To th | Me | 29b. Signeture and | titla of certifier | | 0 | | 29 | . Licens | se numbar | | 29d. Date signe | d (Month, Day, | Year) | | |
| | | 101 | mt. L | emic | lui | | | () | 013 | 69 | 2.10 | .00 | | | |
| | | 30. Neme and addr | ess of person who | completed cause of d | eath (Iten | n 23a) (Type | , Print) | | | | | | | | |
| | | JOHN F.F | ENWICK M | | | | MEDICA | L C | TR P.O. | BOX 640 | HOLLYWO | OD,MD. | 20636 | | |
| Sta | ite | 31. Dete filed (Mon | L Day, Year) | 32. Registr | ars Signa | iture | | | | | | | | | |

DHMH 16 Rev 6/95



/Medical **Examiner**

Funeral

Director with the Maryland Show ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at death

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner

attending physician and for use as the burial-transit Box 68760. Records, P.O. detached signed by the has certificata Division of Vital this

funeral ne Hospital or Attending Ph n 24 hours after death. The Funeral Director: After the Vithin 2

Physician Fdna 11:00 P.M. 4e. Facility Nema (If not Institution, giva street end number) 2103 Carrs Mill Road Fallston Harford 5. Social Sacurity Number If Under 1 Yaer If Undar 24 Hrs. 7. Age (In vrs. last birthdev) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🛛 F Hours 219-16-4149 82 Nov. 12, 1917 W. Virginia Usual Rasidance of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Fallston 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2103 Carrs Mill Road 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Reca - Amarican Indien. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Detas: 1 Never Merried 2 Merried 1 ☐ Yes 200 No Specify: by Specify. 3℃Vidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Induatry Electronics Elementery/Secondery (0-12) College (1-4or 5+) Assembler Manufacturing 17. Fathar's Name (First, Middla, Last) 18. Mother's Nema (First, Middle, Meiden Sumama) Warner Newton Campbell Dora Lockard Louisa 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addreas (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ellen F. Howell - Daughter 4031 Abinrox Drive, Abingdon, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Crametion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Grdns. 2/2/2000 Bel Air, Maryland 22. Nama and Address of Fecility Part Enter the assess, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand the ure. List only one cause on each line. McComas Funeral Home, P.A. Immediete Ceuse (Finei diseese or condition resulting in deeth) CHRONIC LYMPHOCYTIC LEWKEMIA Due to (or es a consequence of) Examiner Sequentieily list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events reaulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of) Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminar? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Pasidance 8 Other (Specify) 1 Yea 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

State Registrar

31. Dete filed (Month, Dey, Year) FEB 2 2000

4 Homicida

(Check only

296. Signature and title of ced

29e. Certifier

leted cause of death (Item 23a) (Type, Print)

D31775 JANUARY 31,200 2112 BELAIR ROAD 21047 KAUSTON, MARYKAND 21047

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medicat Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month, Vest **Physician** Ruth Mae Gordon Jan. 20 2000 1717 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Memorial Hospital Harford If Under 1 Year 8. Date of Birth (Month, Day, Year) 09/25/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foraign **Funeral** Hours Months Deys Country) 1 M 200 F 78 Director 164-16-3129 Usual Realdence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limita Ahow mast be notified at 1 XYes 2 No Directo MD Harford Havre de Grace 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 303 Bourbon Street Funeral 21078 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status r than "natural", or item the Medical Examiner Black, White, etc. filed within 72 hours after of Hygiene. Wher than "natural", or Ner 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 7 le marked other traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth end Mental Clinger Rankin Anna Mae Herr 19a. Informant'a Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) or other tre Paul Gordon- Son 303 Bourbon St., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from State Department of Important: If eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdns. 1/24/00 Aberdeen, MD 21 Signature of Funeral Service Licenses 22. Nama and Addrass of Facility 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, and the control of the control MD 21078 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical due to Phace week Examiner Due to (or es a consequence of): Examiner head The lew requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial 68760 Physician/Medical Due to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Pas certificate 1 Yes 2 ₽No 1 Yas 20 No or Attending Physicien: funeral director, 25. Was case referred to medicet examiner? 8 26. Place of Deeth (Check only one) Hospitet: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Dete of fnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? After 5 Pending investigation 1 Natural Division To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aftr completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

10 State Registrar

31. Date filed (Month, Day, Year) JAN 2 4 2000

KARMACHANDRON.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of portifier

NMR, 32 Registrar's Signature

Allerdy Physican

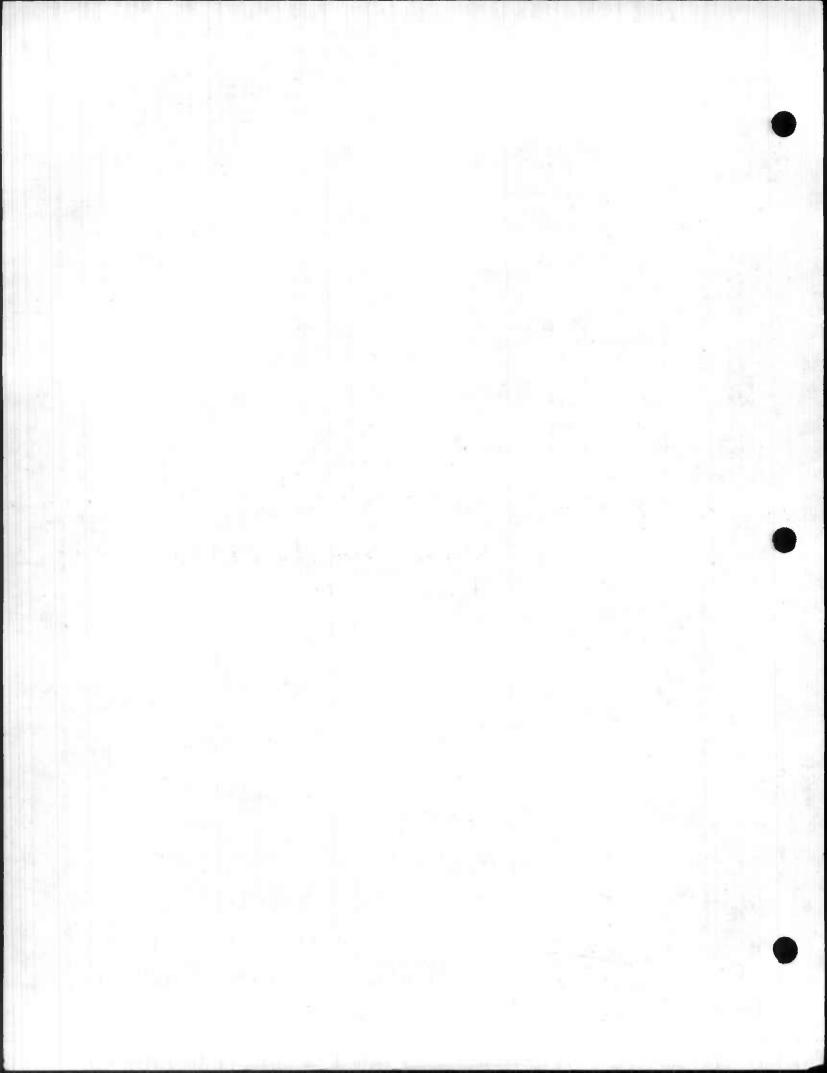
11 DECRWOODS CT GLENDRM, MARYLAND 21057

1)20316

29d. Date signed (Month, Day, Year)

22/2000

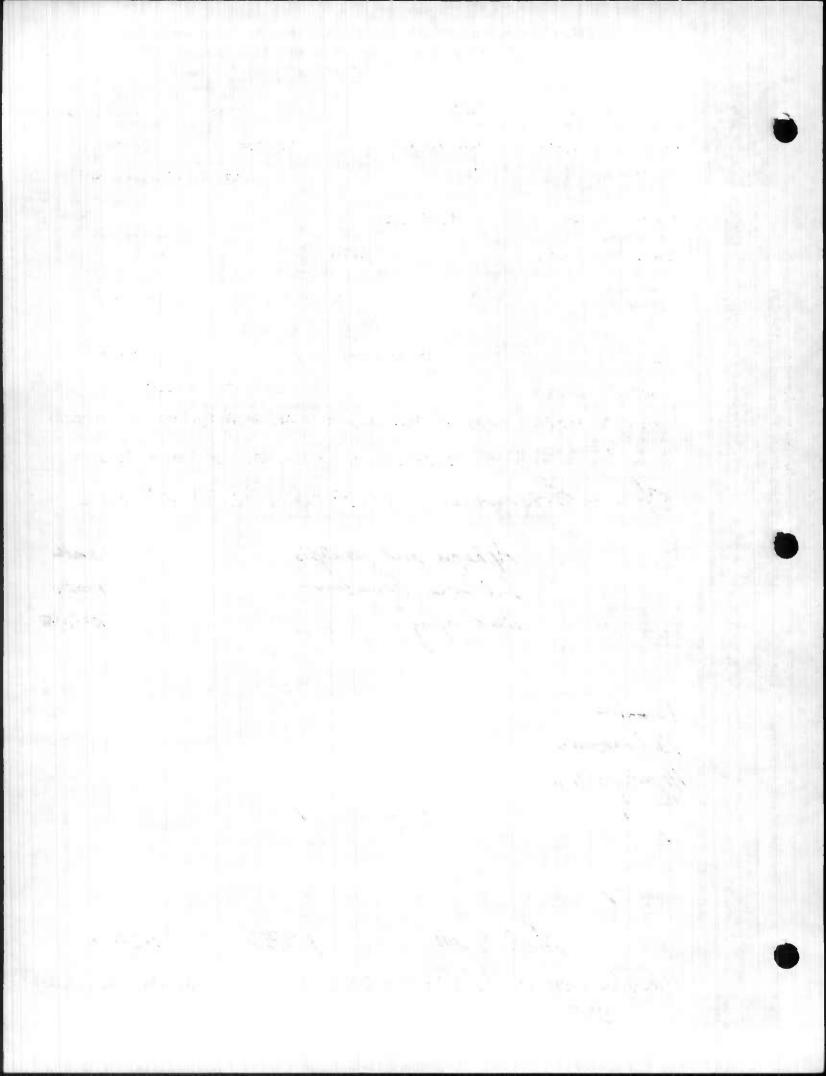
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State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 0 9

| | | Certificate | of Death | Reg. No | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------|
| I Section 1 | 1. Decedent'a Name (First, Middle, Last) | | | 2. Date of Death | 8/18 | 3. Time of Death |
| Physicia: /Medica | | CS | | Jan 2 | , | 12:20 AM |
| Examine | An Cartifus Name of and institution when about and asset and | | 4b. City, Town, or Lo | | County of Death | 1.2.4.20 |
| Funeral Director | Genesis ElderCare - The 5. Social Security Number 6. Sex 7. Age (| Pines In yrs. last birthday) Yrs. Months D | ays Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 2, 19 | | laca (Stete or Foreign try) |
| 2 3 | Usual Residence of Decedent 10a, State 10b, County 1 | Oc. City, Town or Location | | | | 0d. Inside City Limits |
| death with the Maryland rms 23a or 28a-f show rmset be notified at | Constitution of the consti | St. Michaels | | | | Yas 2□No |
| Diter death with the Mar r feers 23s or 28s-f s niner must be notified | 10e. Street and Number 204 E. Maple Ave. | 10f. Zip Co 2160 | 63 | U | I.S.A. | |
| 6 28 | 3 Widowed 4 □ Divorced Yaar or Datas: | er In U,S. 13. Was Deceden If Yas, specify 1 ☐ Yes 2 ☐ | t of Hispanic Origin? (Spe Cuban, Mexicen, Puerto I No Specify: | cify Yas or No- Rican, atc.) | 14. Race - Americ Black, White, o Specify: Whi | etc. |
| 72 h | 15. Decedent's Educetion (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 6 | 16a. Decedent's Usual C (Giva kind of work of | dona during most of workli | 16b. K | Ind of Business/Inc | dustry |
| 121 within ne. | Elementery/Secondary (0-12) College (1-4or 5+) | | 2000 | | Thootro | |
| Hygied No. | 12 6 | College Pro | | (First, Middle, Meiden | Theatre | |
| aryland should be file ond Mental Hy marked oth umatic event | | | | Gladys Bo | | |
| aryla aryla should Ind Menid Menid Inmerice | 19e. Informent's Neme/Raletionship (Type, Print) | 19b. Mailing Address (S | treet end Number or Rure | | | Code) |
| t. M. sand 2 saith e n 27 is | Jennifer VanPernis Daugh | ter 5412 Kemps | ville St. No | orth Spring | field, V | irginia |
| Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours at Department of Health end Mental hygiene. Important: if Nem 27 is marked other than "natural; or any injury or other traumatic event, the Medical Examples. | 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. Place of Disposition (Neme cematary, cramatory or othe Capitol Cremat | r plece) | | ocation - City or To rer, Dela | |
| Balti permit. Departr Importa any Inju | 21. Signatura Funeral Service Licensea | 22. Name and A | Addrass of Facility n E. Leonard Talbot St. | | | |
| Physician /Medical Examiner | 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) | a death. Do not enter the moda o | of dying, such as cardiac of | | 1 | Approximate Interval Between Onset and Death |
| p ₀ sit | Subde | git ful por to (or es a consequence of): wel Remuf | ma | | | months |
| Records, P.O. Box 68760, The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the buriel-transit | Cause (Disease or Injury that Initiated events Du resulting In death) Last | ue to (or es e consequence of): | | | / | 10-4.98 |
| of Vital Records, P.O. Box hystolan: The lew requires that the death of his certificate hes been signed by the attend il director, page 2 should be detached for us. | Part II. Other eignificant conditions contributing to death but r | not resulting in the underlying cour | se given in Pert I. | 23b. Did tobacco | | the cause of death? |
| cords w requires been sign should be | Parkinsonism | | | 24a. Was an auto performed? | avi | ere autopsy findings allable prior to mpletion of cause death? |
| Vital Relevicion: The levicertificate hes | Hypothewordism | | | 1 ☐ Yes 2 | V | Yas 2□ No |
| Vital I | 25 / as cese referred to medicel | | 28. Place of Death | (Check only one) | | |
| of V hysic this co | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient | | | me 5 Residence | | y) |
| or Attending For the deeth. Ifter deeth. Ifter deeth. In by the funer | 27. Menner of Death Natural 5 Pending Investigation 2 Accident Suicide Could not be determined 28e. Place of Injury building, etc. (| (ear) 28b. Time of Injury M 28c. - At home, farm, street, factory, o | Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how Inju 28f. Location (Street ar City or Town, State | nd Number or Rura | al Route Number, |
| To the Hospital or within 24 hours after To the Funeral Dir completely filled in | 29a. Certifier (Check only one) Certifying Physician: To the best of read manner states and manner states | caminetion and/or investigation, in | | | | |
| To the within To the comple | 29b. Signature and titla of certifiar | 29c. L | DZS993 | 29d. Da | ta signed (Month, | |
| | 30. Name and eddress of person who completed cause of deel MICHALL CROWLLY MD | 508 IDLEWIL | D AVENUE | EAS | TON, MD | 21601 |
| State Registrar | INN 9 1 2000 N /2% | s Signature &. A. | parks/ | | , | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 0 5 1 1 0

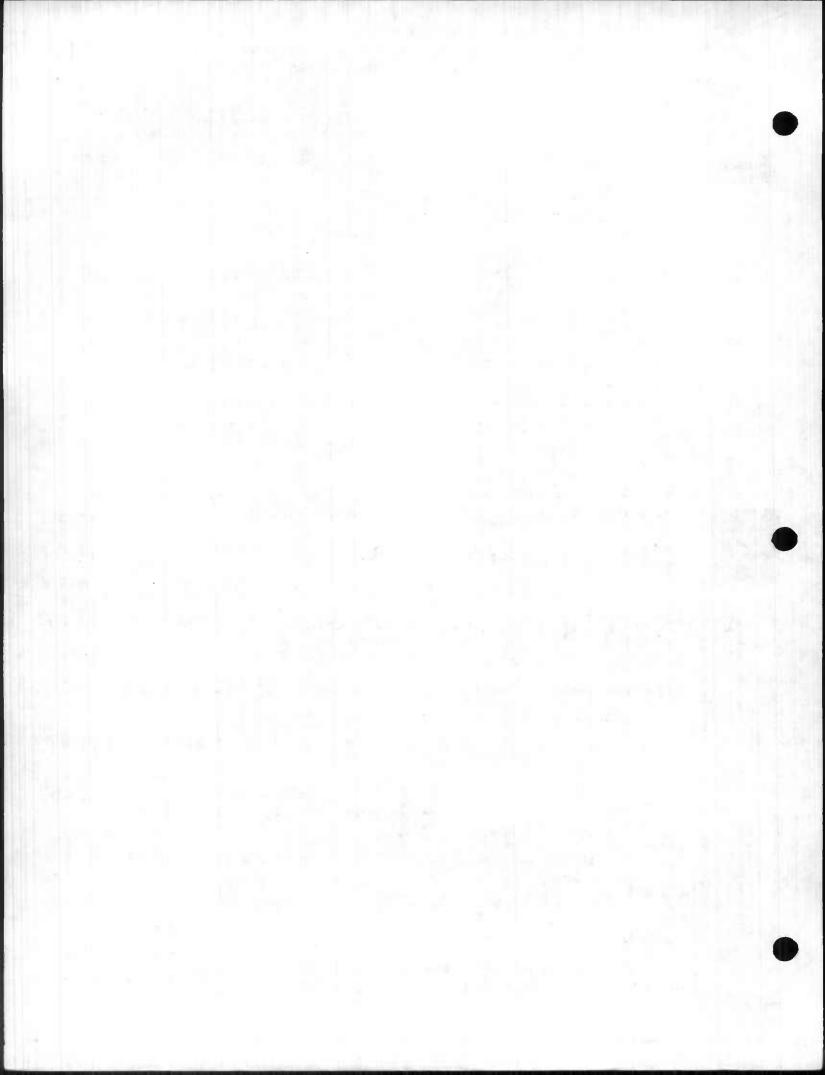
| | Decedent's Neme (F) | iret Middle I = | of) | | | ertifica | 10 01 | Dodiii | 2 Deta | of Death | g. No. | | 3 Time | of Death |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------|------------------------|-------------------------------|-----------------------------------------|----------------------|------------------------------------------------|-----------------------------------|-------------------------------|-------------------------------------------------|-------------|-----------------------------|-------------|
| hysician | | | | | | | | | Mon | | Dey | Year | | |
| /Medical | Charles | | Gandy | | | | | 41. Oh: Tour | | UARY | | 000 | 11:2 | 4 A.M |
| xaminer | 4a Facility Name (If no | (A-13)-1-1-1 | | | | | | | , or Location of | | 4c. County | | | |
| , | MALCOLM GR | | | | In a filtration | . If I lod | ar 1 Yaa | CAMP SP | | | PRINCE | | | |
| neral ector | 5. Social Security Numb 516-34-845 | | ex M 2□F | . Aga (In yrs | | Month | | | Min. (Mon | of Birth th, Dey, 1 ary | (ear) 11,193 | Cour | ntry) | or Foreign |
| - | Usuel Residence of Dec 10a. State 10 | b. County | | 100.0 | ity, Town or | Location | | | | | | 1 | IOd. Inside | City Limits |
| | | 2-1/22 | | | | | | | | | | | | • 20 No |
| be notified Directo | Maryland Pr | | eorges | Fo | restvi | | in Code | | | 10 | - Chi-on of h | Albert Cour | | 2121 |
| | | | | | | 101. 2 | ip Code | _ | | | g. Citizen of V | Allet Con | ntry r | |
| era! | 8508 Bonny | y Drive | 12. Wes Dece | lant Ever in I | 10 1 | 3 Was Das | 2074 | | 2 /Coocibi Voc | | J.S.A. | e - Americ | an Indien, | |
| by Funeral | 11. Meritat Stetus 1 Never Married 3 Widowed 4 | | Armed Fore | es? | | | 2X No | Hispanic Origin ban, Mexican, P Specify: | Puerto Rican, et | c.) | Blad | white, | etc. | |
| Completed | 15. | Decedent's Ed | lucation | | 16a. De | cedent's Us | ual Occu | petion | f working | 14 | 6b. Kind of Bu | usiness/In | dustry | |
| pjd | Elementery/Seconde | | College (1- | 4or 5+) | life | . DO NOT | use retin | during most of ed) | WORKING | | | | | |
| E O | 12 | | | | Sale | esman | | | |] | Retail | Sale | s | |
| Be C | 17. Father's Nema (Firs | it, Middla, Last) | | | | | | 18. Mother's | Neme (First, A | Aiddle, M. | aiden Suman | 10) | | |
| 0 | Charles E. | . Gandy | | | | 200 | | Mir | na Wil | son | | | | |
| | 19e. Informent's Name. | | | | | | | et and Number o | | | | Stete, Zip | Code) | |
| | Stella Gand | dy / wi: | fe | | 8508 | Bonr | ly Dr | . Fores | stville | , MD | 20747 | | | |
| 5 | 20e. Method of Disposit 1 Burial 2000 4 Donation 5 D | remetion 3 🗆 | | IGIG | Pleca of Discametery, of Line | | | ece) itory Fe | Dete | | 0c. Location - | | | ſD |
| any injury once. | Sanature of Funere | | - | | | 22. Neme | end Addr | ess of Fecifity I | t. Lin | coln | Funera | al Ho | me | |
| | 23e. Part1. Enter the d shock, or heart fe | lisease or com | nlications the ca | used the dea | | | | | | | | | Approxim | ete |
| cian lical iner | immediate Cause (Fine disease or condition resulting in death) | 0 | MULTI- | INFARC | | ENTIA | | | | | | 1 | Interval B Onset and | d Deeth |
| ē | | | RESPIR | | | | | | | | | | 24 но | IIRS |
| Examiner | Sequentially list conditi | ions | b | | or es a con | | f): | | | | | | 24 110 | OILO |
| EX | Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Diseese or inju- | diate | HYPERT | | | | | | | | | | 1 37174 | D |
| edical | that initiated events | | c. HIFEKI | | or as a cons | sequanca o | h: | | | | | | 1 YEA | K |
| as the bunal-transit Medical Examir | resulting in death) Last | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , | | | | | i | | |
| use a | | | d | | | | | | | | | 1 | | |
| etached for use Physician/ | Part II. Other etgnifican | nt conditions o | ontributing to dea | th but not re | sulting in the | e underlying | cause o | iven in Pert I. | 231 | o. Did tob | acco uee co | ntribute t | o the caus | e of death? |
| detached for use | | | | | | | | | | 112 Ye | 2 No | 3 □ Pro | bably 4 | Unknow |
| should be detac | | | | | | | | | _ | | | | | |
| pg pg | | | | | | | | | 248 | . Wes en | | 24b. W | era autops railable pric | y findings |
| . page 2 should | | | | | | | | | | porronni | 001 | CC | ompletion o | |
| Com | | | | | | | | | | 1∏ Yes | 2 🕱 No | 11 | □Yes 2 | □No |
| , o | 25. Was case referred | to medicat | | | | | | 26 Place of | Deeth (Check | | | 1 | | |
| director. | examiner? 1 ☐ Yes 2 🕱 No | | Hospitel: | patient 2[| ☐ ER/Outpa | tient 3 | 0 | ther: | ing Home 5 | | | or (Coosi | 60 | |
| | 27. Menner of Deeth | | | | 28b. Time | | | | | | v injury occur | | 197 | |
| m - | | Pending investigation | | | Injur | М | | Yes 2□No | | | | | | |
| m - | 2 Accident | ☐ Could not be | 289. Preca (| of Injury - At I | ify) | street, tect | ory, oπicε | | | or Town, | Stete) | oer or mun | at Horita IA | imber, |
| by the funeral | 2 Accident | Could not be determined | buildin | | | | | | | | | | | |
| by the funeral | 2 Accident 3 Suicide 6 4 Homicide | determined Certifying Ph | ysician: To the baliner: On the baland menna | is of examin | owledge, de etion end/or | eth occurre Investigation | nd at the ton, in my | time, date and p opinion, deeth | plece, end due occurred et the | to the ce | use(s) end mo te and place, | enner as s | stated. to the cause | e(s) |
| by the funeral | 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only 2 | Certifying Ph | ysician: To the base | is of examin | owledge, de etion end/or | Investigation | on, in my | time, date and p opinion, deeth | plece, end due occurred et the | time, da | use(s) end mo te and place, d. Data signe | end due t | o the cause | |
| in by the funeral ertification: | 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one) | Certifying Ph | ysician: To the base | is of examin | owledge, de etion end/or | Investigation | on, in my | opinion, deeth | plece, end due occurred et the | time, da | te and place, | end due t | Dey, Year, | |
| ector: After the by the funeral tiffication: | 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one) | Certifying Phy Medical Exam of certifier | ysician: To the base and menni | is of examinar stated. | etion end/or | Investigation 2 | on, In my | opinion, deeth | occurred et the | time, da | d. Data signe | end due t | Dey, Year, | |

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygien 0 05 1 1 1

| | | | | | | | C | ertifica | te of | Death | | | Reg. No. | 0.0 | , , , , |
|-----------------|---------------------------------------------------------------------------------------------|-------|-----------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------|---------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------|-----------------------|-----------------------------------------|-----------------------------------|------------------------------------|---------------------------------------------------------------|
| | | | ecedent's Nem | e (First, Middle, La | st) | | | | | | | 2. Date of De | ath | Maria | 3. Time of Death |
| | Physiciar /Medica | | Bennaje | anne NMN | Gilmer | | | | | | | Jan | 31 2 | Year | 6:00 am. |
| | Examine | 4a i | | | e street and numb | - | | | | | | ocation of Death | | | |
| i_ | | | | | l Hospita | | | 1 Hillord | er 1 Year | | _ | town | | _ | County |
| | Funeral Director | | 202-24- BI Residence of | 2820 | 5ex 7. I□M 20 X F | Age (In yrs. | 68 Yrs. | Months | | | Min. | 8. Dete of Bird (Month, De May 29 | y, _{Year)} | | place (State or Foreign http) usylvania |
| | land w | | Stete | 10b. County | | 10c. Cit | y, Town or | Location | | | | | | 1 | 0d. Inside City Limits |
| | Mary | | 1D | Washingt | con Co. | H | lagers | stown | | | | | | | 1 ☐ Yes 2X No |
| | death with the Maryland ms 23a or 28a-f show f must be notified at | | Street and Nur 18526 I | | ttage Roa | ad | | 10f. Z | ip Code | 21742 | | | 10g. Citizen of U | What Coun | |
| 21215-0020 | al', or its | 2 : | Meritel Stetus Never Marri Widowed | ed 2[XMerried 4 Divorced | 12. Wes Decede Armed Force 1 Yes 2! If Yes, Give Yeer or Dete | s? XNo | S. 1 | 3. Was Dec If Yes, sp | | | gin? (Sp n, Puerto | ecify Yes or No Rican, etc.) | 14. Rec Bie Specify | ce - Americ ck, White, y: Wh | |
| 5-0 | 72 h | | (Spec | 15. Decedent's E | ducation ade completed) | | (G | cedent's Us | ork done | during mos | t of work | ing | 16b. Kind of B | usiness/inc | dustry |
| 121 | ed within 72 ho ygiene. her than "natur ft, tre Weden! | E | ementery/Seco | | College (1-4d | or 5+) | life | DO NOT | use retire | od) | | | | | |
| | | | 12 | (First, Middle, Last | 0 | | He | omemak | er | 18 Moths | ar's Name | a (First Middle | Own H | | |
| Maryland | Sep a | | Arch Ni | | | | | | | | | bertson | | 10) | |
| ary | # SEE | | . Informant's Ne | me/Reletionship (| Type, Print) | | 19b. Me | eiling Addre | ss (Stree | t and Numbe | er or Run | al Route Numb | er, City or Town, | , State, Zip | Code) |
| - | and 2 aith a 27 le | | Jacob W | illiam Gi | ilmer, Jr | ./Hus. | 18 | 526 Ir | ndiar | Cott | age | Rd., Ha | gerstow | n, M | 21742 |
| Baltimore | artment of He ortant: if Her injury or oth | | | | Removel from Ste | te C | emetery, c | sposition (National Information of Control Information Control Information Control Information (National Infor | other ple | | 1 | Peb.4 | 20c. Location | | own, Stete Maryland |
| Balt | Department importar any injure page. | 21. | Signature of Fu | neral Service Licer | nmerm | un | | Dougl | as A | ess of Facility Fier ern B | v Fi | neral I | Home erstown, | .Marv | land 21742 |
| | | 238 | Pert1. Entelul shock, or hee | ne diseese, or com rt feilure. List only | plications thet caus one cause on each | sed the deeth | n. Do not | | | | | | | | Approximete Intervat Between Onset and Death |
|) | Physician /Medical Examiner | dise | nediate Cause (lese or conditio liting in deeth) | Finel n | Sep | tic | Sh | ock | , . | | | | | 1 | 24 4ns. |
| L. | ةِ السا | | , | | Dos | Due to (0 | ras a con | sequence of | ect | · | Sa | ceal | D.4 | | I week. |
| | cate be executed physician and s the burial-transit | Seq | uentietly list co | nditions, | b | Due to (o | ras a cons | sequence of | | 7 | 2 | | | 1 | |
| 68760, | Sician burial | Ceu | uentietly list co y, leading to im se. Enter Unde se (Dtsease or initieted events | rlying injury | . Melh |) Ke | 28154 | ant | 2 | app | 10 | used | us. | 10 | 3 days. |
| x 687 | E 5 | resu | iting in death) l | ast | . Di | a bei | es es | equence of | lle | dit | us | · · | | 0 | 3 days. |
| Вох | death ce | | | | | | | | | | | | | 1 | 1/ |
| P.0. | by the lached | Part | II. Other signif | Must Ac | ontributing to death | Sel | ie | | | ven in Pert I | | | tobacco uae co Yee 2□ No | 3 Proi | bably 4 10 Onknown |
| cords, | v requires that been signed should be defended by Pletted by Pletted by P | | | ate | ial | file | Elle | Aro | n | | | | an eutopsy med? | CO | ere autopsy findings allable prior to mpietion of cause |
| of Vital Record | The lay ate has page 2 | | | 250 10 | | - | | | | | | 10 | Yes 20 No | | death? |
| Z Z | Physician: The this certificate ral director, page Co.: To Be Co.: | | Was case reterioxaminer? | | Hospitel: | | | | 100 | hoe | | h (Check only o | | | |
| o | Pi sign | | Ves 2 denner of Death | | 28e. Dete of I | | ER/Outpat | - | UA | | - | | dence 8 Ott | | y) |
| lon | Attending in death. Sctor: After by the funer | 27. | PNeturet □ Accident | 5 Pending | (Month, | Dey Year) | 28b. Time Injur | | 28c. Inju Wo | wk? Yes 2□ | | 280. Describe | now injury occur | 100 | |
| Division | tal or Attending P rs after death. at Director: After t led in by the funera Certification: | | Suicide Homicide | 6 Could not be determined | 288. PIECE OF | Injury - At ho etc. (Specif) | ome, ferm, | street, fecto | ry, office | | | 28f. Location (: City or Ton | | ber or Rura | al Route Number, |
| | Hospi 24 hou Funer stely fill | | Certifier (Check only one) | 1 ☐ Certifying Ph 2 ☐ Medical Exam | yelclan: To the be niner: On the basis end menner | of examinet | wledge, de ion and/or | eth occurre Investigatio | d et the t n, in my | ime, date an opinion, dea | d place, th occur | and due to the red et the time, | cause(s) and m dete end plece, | anner es si end due to | lated. the cause(s) |
| | within 2 to the comple | | Signature and | titie of certifier | | | | 2 | 9c. Licen | se number | | | 29d. Dete signe | d (Month, | Day, Year) |
| | | |) A | rda_ | | m h | D. | | D45 | 031. | | | Jan 31 | 00 | |
| | | 30. N | leme and addre | ess of person who | completed cause o | f death (Item | 23a) (Typ | e, Print) | 1.7 | | | 00 0 | | | WAN MO |
| | | 3 | HAHAE | b Day Year's | BIOCH | 27 | 194 | 14-C | 49 | 1045 | BV | K61 1K | to lead | 43 10 | 21742. |
| | State | 31. [| Dete filed (Mont | B 0 1 200 | 32. 1990 | strer's Signe | Ly Ly | 1 | 00. 11 | | | | | | |



BALTIMORE, MARYLAND 21215-0020

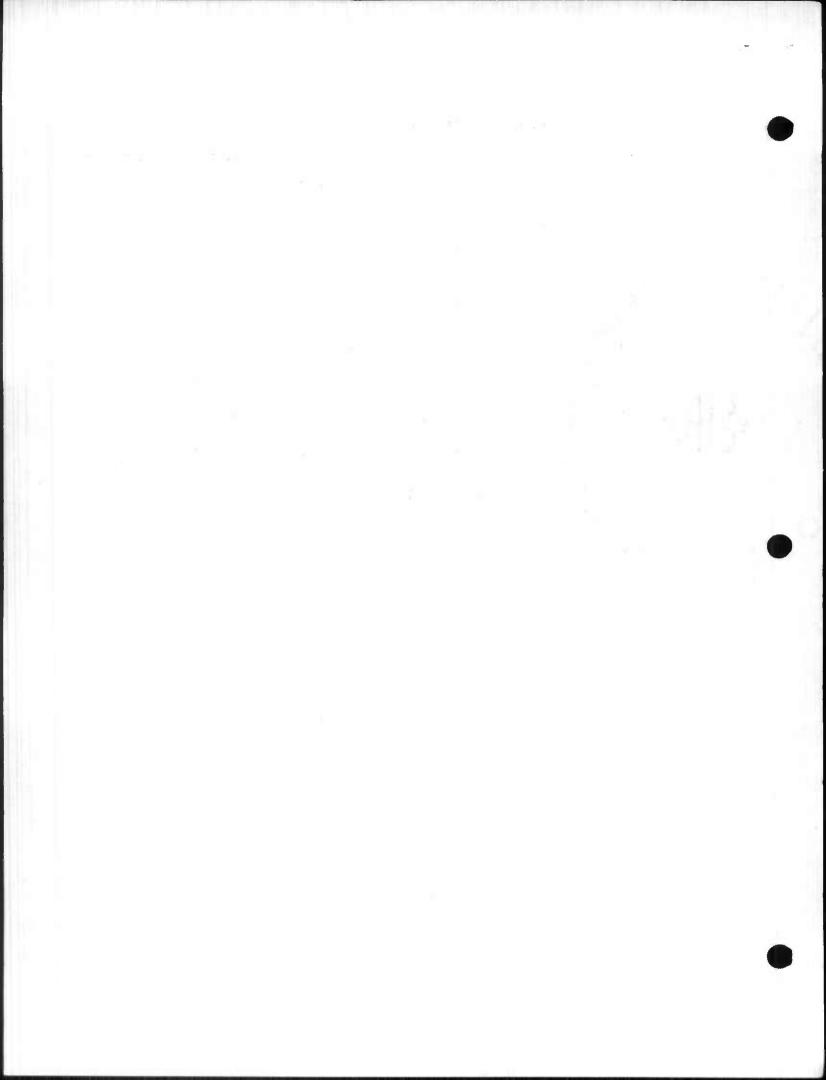
DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and competely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | | | MENTAL HYGIEN | E | |
|-------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------|--------------------|------------------------------------|---------------------------------------|--------------------------------|-----------------------------------------------------|
| i | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | Ö, 20 Ö Ö' | 3. TIME OF DEATH 8:40 a. M |
| | John W | | ES, JR. | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | A. Bit | RTHPLACE (State or Foreign |
| | 215-30-7763 218-30-7763 218-36 | | | NTHS DAYS | HOURS MIH. | Sept. 6, 1 | 1935 Man | cyland |
| œ | 9a. FACILITY NAME (If not institution, give 7511 Dam #4 Road | | 96 | Sharp | Sburg | ATH | Washin | gton |
| 2 | RESIDENCE OF DECEDENT | | | | | | | |
| DIRECTOR | Maryland Wash | nington | | psburg | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 100. STREET AND NUMBER 7511 Dam #4 Roa | a.d | | 101 | . ZIP CODE 2178 | 2 | 10g. CITIZEN O | F WHAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | IN U.S. ARMED | 13. WAS DEC | | IC ORIGIN? (Specify Yes | | ACE — American Indian, |
| BY FI | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 XYES IF YES, GIVE WAR OR D 1958-1964 | | | ecify Cuban, Mexices ZX NO Specify | n, Puerto Ricen, etc.) | В | lack, White, etc. pecify: White |
| | 15. DECEDENT'S EDU (Specify only highest grad | UCATION le completed) | 16a. DECEDENT'S USU (Give kind of work life. Do NOT use re | done during mo | ON st of working | 16b. KIND OF BUS | SINESS/INDUSTR | Y |
| COMPLET | Elementary/Secondary (0-12) 0-9 | College (1-4 or 5+) | service | | cian | foo | d equip | ment |
| w I | 17. FATHER'S NAME (First, Middle, Lest) John | William | | | 18. MOTHER'S NA | ME (First, Middle, Maiden Mary Hel | _{Sumame)} .en Mull | enix |
| TO B | 190. INFORMANT'S NAME (Type/Print) Mrs. Bonita Grove | es - wife | | | | rpsburg, M | | |
| | 20e. METHOD OF DISPOSITION 1 🔀 Burlel 2 🗀 Cremation 3 🗀 Ren 4 🗀 Donation 5 🗀 Other (Specify) | moval from State Cal | b. PLACE AND DATE OF D metaly, crematory or other edar Lawn | esposition (Na | al Park | | CATION — City of | r Town, State yn, Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE L | | / / | _ | ND ADDRESS OF FAC | | | eral Home |
| | & SCART | miller | uled | ,415 E | ast Wils | on Blvd., | Hagerst | own, Maryland |
| | | complications that cause List only one cause on a | d the death. Do not sech line. | enter the mo | de of dying, auci | h se cerdiac or respi | iratory arrest, | Approximate Interval Between Onset and Death |
| | IMMEDIATE CAUSE (Finei disease or condition resulting in death) | · P(| neta | te. | - Co | Mana | oma | 1 2 years |
| | _ | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate | b. DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| FIGS SA | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | C. DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| CERTI | resulting in deeth) LAST | d | | | | | | |
| AL | PART II. Other eignificent condition | ons contributing to deeth | but not resulting in t | the underlyin | g ceuee given in | Part i. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDIC | | | | | | 1 🗆 YES 2 | 740 | OF DEATH? |
| Σ N | DID TOBACCO USE CONT | TRIBUTE TO CAUSE O | OF DEATH YES | □ NO | UNCERTAIN | V | ` ` | 1 PES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Out | | THER: | X | o (1) out 1 out 1 | | |
| PHYS | 27. MANNER OF WEATH | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | | URY AT ORK? | 8 Other (Specify) 28d. DESCRIBE HOW | NJURY OCCURE | , |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | Y — Al home, ferm, stre- | | YES 2 NO | 28t. LOCATION (Street | and Number or Ru | Inute Number |
| TED | 3 Suicide 8 Could not be 4 Homicide determined | building, etc. (Spe | ectfy) | er, rectory, offic | | City or Town, Stete | | TO NOTE HUMON, |
| MPLET | one) | SICIAN: To the best of my know | | | | | | |
| 8 | 2 MEDICAL EXAMIN | NER: On the beele of examination | on and/or investigation, i | in my opinion, o | leath occured at the | | | se(s) end menner ee stated. NED (Month, Day, Yeer) |
| O BE | Harel | Usa _ | -h | M | DH6 | 473 | ▶ \ / | 31/00 |
| F | 30. NAME AND ADDRESS OF PERSON W | THO COMPLETED CAUSE OF D | 363 (Type, Pri | VOO O | elandi | A10 . Ha | Iden | mula mi |
| - 4 | 31. DATE FILED (Month, Day, Year) | ALL LULY A | | LXX | CA CALLY | 104 . 110 | | (111) |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. FOUND 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Day 22, 2000 1053 JANUARY Margaret Gibson FOUND 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, giva street and number) 井103 PHINCE GEORGES 7609 SOUTHERN AVENUE TEMPLE HILLS If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Deta of Birth Days 1□M 2DXF Months 577-28-2081 78 Nov. 20,1921 Washington DC Usual Rasidance of Decedent 10d. Inside City Limits 10a Stata 10b. County 10c. City. Town or Location Maryland Prince George's Temple Hills 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2609 Southern Avenue Apt. 103 20748 U.S.A. 12. Was Decadant Ever in U,S Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14 Rece - American Indian Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaer or Detas: 1 □ Never Married 2 □ Married 1 ☐ Yaa 2 ☒ No Specify: Specify: Black 3 MWidowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Collega (1-4or 5+) Elamentary/Secondary (0-12) 12th N/A Accountant Federal Government 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) George Tover Newby Mary 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Reletionship (Type, Print) Clarence Gibson (Son) 8901 Allentown Road Ft. Washington MD 20744 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 26, 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Ramoval trom Stata 4 ☐ Donation 5 ☐ Othar (Specify) Jan. Lee Crematory Clinton, Maryland 2000 21. Signature of Funaral Service Licanses 22. Nama and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 23e. Part1. Enfar tha disease, or complications that caus. In teath. Do not anter tha mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death Immadiata Ceuse (Finel AKTERIOSCUEROTIC CARDIOVASCULAR DISEASE disease or condition rasulting in daath) Dua to (or as a consequence ot): Sequentially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Ceusa (Disaasa or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequance ot): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No DIABETES MELLITUS 24b. Wara autopsy tindings available prior to completion of causa of daath? 24a. Wes an autopsy N/A 2 X No 1 □ Yas 2 □ No 1 Yas 25. Wes casa refarred to medical axaminar?

1 Yas 2 □ No 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 ER/Outpetient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 5 Pending Invastigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, ferm, straet, fectory, office building, atc. (Specify) 4 T Homicida

Division of Vital Records, P.O. Box 68760,

that the death certificate be executed physician are the buriel-t attending p signed by the a d be detached f The law requires should s is certificate has director, page 2 this funeral After death. after death Director: /

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be 1

Directo

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiena. Important: If them 27 is marked other than *--- any injury or other traumethand.

Physician /Medical

Examiner

Examiner

Physician/Medicai

þ

Completed

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Certification:

29a. Cartitian

Hospital or Attending Physician: To the Hospital or within 24 hours aft To the Funeral Dis completely filled in

Medical 6

State Registrar 29b. Signature, CILL MARIO F.

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number

29d. Dete signed (Month, Day, Year)

euse ot deeth (Hem 23a) (Type, Print)

HOSPITAL DRIVE CHEVERLY MARYLAND 20785 3001

82. Registrar's Signatura

A LONG COLUMN CO

Service Service

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** RODNEY E. GRAHAM JANUARY 19,2000 5:00pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12607 THRUSH PLACE UPPER MARLBORO PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Months, Day, Year) | 12-24-64 Birthplace (Stata or Foreign Country) 5. Sociel Security Numbar 7. Aga (In yrs. last birthday) **Funeral** WASHINGTON DC XXM 2 F Yrs. 578-96-3999 35 Director Usual Rasidance of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show MXYes 2 No Director MD PRINCE GEORGES UPPER MARLBORO 28a-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò Items 23a 12607 THRUSH PLACE 20772 Funeral UNITED STATES death 14. Race - American Indien, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yas 2 ☐XNo If Yas, Giva 1 ☐ Nevar Married 2 X Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes ¾ No Specify: Specify: BLACK ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Physics. Important; if fleen 27 is marked other than any injury or other traumatic. Elementery/Secondery (0-12) College (1-4or 5+) MECHANIC PRIVATE SHOP 17. Fathar's Nama (First, Middle, Lest) 18. Mother's Nama (First, Middle, Maiden Surname) Be HERBERT GRAHAM VESTREE WELLS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSHEA GRAHAM / wife THRUSH PLACE, UPPER MARLBORO, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Ramoval from Stata FOREST HILLS CEMETERY 1-25-00 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee 22 Name and Address of Facility POPE FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Physician tomach Cancer /Medical Immediata Cause (Final disaase or condition resulting in deeth) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the cause of death? P.O. 2 3 Probably 4 Unknown 1 Yes 2€ No be det Records, þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yas 20 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was casa raferred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 Naturel 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29b. Signature and titla of pertiling 29c. License number 29d. Dete signed (Month, Day, Year) DO052382 JANUARY 25,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MOLIERI 6410 ROCKLEDGE DR. SUITE 625

DHMH 16 Ray 6/95

Registrar

31. Data filed (Month, Day, Year)

FEB 0 1 2000

32 Registrar's Signatura

FEE 0 1 2000 por a. James

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | Certificate of Death | Reg. No. | 05115 |
|-------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| | Dhysician | 1. Decedent's Neme (First, Middle, Last) | | 2. Date of Death Month Day | 3. Time of Death |
| | Physician /Medical | Ellis Lee Godwin | | January 28, 20 | 00 2:30am |
| | Examiner | 4a Facility Neme (If not institution, give street end number) Southern Maryland Hospital | 4b. City, Town, or U | | e George's |
| | Funeral Director | 5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last 7. Usual Residence of Decedent | t birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Dey, Year) May 9, 1921 | 9. Birthplece (State or Foreign Country) Washington, D.(|
| Handana | a or 28s-t show be notified at | 10a. Stete 10b. County 10c. City, T | Town or Location rningside | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| - | 23a or 28a-fr ust be notifier | | 10f. Zip Code 20746 | 10g. Citizen of W United | |
| 5-0020 | rai, or items 23a Examiner must b | 3 ₩ Widowed 4 Divorced If Yes, Give Yeer or Detes: | 13. Wes Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerto | o Rican, etc.) Bleck | - American Indian, c, White, etc. Black |
| 5-0 | rigiere. Nr the Medical. Completed | 15. Decedent's Education (Specify only highest grade completed) | 6a. Decedent's Usuel Occupation (Give kind of work done during most of work | king 16b. Kind of Bus | siness/Industry |
| 121 | the Man | Elementery/Secondary (0-12) College (1-4or 5+) | 'life. DO NOT use retired) Printing Office | Govern | mant |
| P | | 17. Father's Neme (First, Middle, Last) | | ne (First, Middle, Meiden Sumeme | |
| /lan | Mertal H arked of affic ever To Be | Ellis Vincent Godwin | Virgin | nia Lee Thompson | 1 |
| Mar | BEE | 19e. interment's Neme/Reletionship (Type, Print) | 19b. Meiling Address <i>(Street and Number or Ru</i> 6717 Larkspur Rd. Morr | | Stete, Zip Code) |
| Baltimore, | nent of He ent if Item ary or othe | 1 Buriel 2 □ Cremetion 3 □ Removel from State cerm | e of Disposition (Name of etery, cremetory or other piece) Ony Memorial Park | Dete 20c. Location - 0 2/3/00 Landover | City or Town, State |
| Balt | Departi | 21. Signeture of Funerel Service Licensee | 22. Name and Address of Facility Alexander S. Pope 5538 Marlboro Pike | | id. 20747 |
| | hysician /Medical xaminer | | | | Approximate tnterval Between Onset and Deeth |
| 3 | in and instransit | o Type II | SESPIRATORY s a consequence of): DIABETES | MOZUTUS | > |
| 1 68760, | physician and as the burial-transit | Cause (Diseese or injury | | | |
| ox 68760, | 5 5 | resulting in death) Last Due to (or es | s e consequence of): 5TAGE REY | AL DUFA | 15 |
| m f | attendii d for use | Part II. Other should continue and the state of cate but and units | | | |
| P. 0 | ed by the attendidetached for use | Pert II. Other significant conditions contributing to death but not resulting | ig in the underlying cause given in Pert I. She Expression in Pert I. | 1 Yes 2 No | tributs to the cause of death? 3 Probably 4 Unknown |
| of Vital Records, | cate has been signed by the attendi page 2 should be detached for use Completed by Physician/ | Amputation | ¥.S | 24s. Wes an autopsy performed? | 24b. Were autopsy tindings available prior to completion of cause of death? |
| H F | s certificate has b director, page 2 s | | | 1□ Yes 2 No | 1 □ Yes ZÜNo |
| E E | ertifica ector, j | 25. Was case reterred to medicat examiner? | 26. Place of Dee | oth (Check only one) | |
| | # - | 1 ☐ Yes 3 ☐ No Hospitel: 1 Hopatient 2 ☐ ER | ## A Court | ome 5 Residenca 6 Othe 28d. Describe how injury occurre | |
| 5 | a brector: After the in by the funeral Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Pleca ot tnjury - At home building, etc. (Specify) | , tarm, street, fectory, office | 281. Location (Street end Number City or Town, State) | er or Rurel Route Number, |
| The Hosoital | within 24 hours To the Funeral completely filled Medical C | 29a. Certifier (Check only one) Control one) Control one (Check only one) Control one (Check only one) Control one dge, death occurred at the time, dete and place, end/or investigation, in my opinion, deeth occu | , and dua to the cause(s) and mar rred et the time, date end place, a | nner as stated. and due to the cause(s) |
| ام ا | within 24 To the Fu complete | 29b. Signatura and title of certifier | 29c. License number 029205 | 29d. Dete signed | (Month, Day, Year) |
| (| 6) | 30. Netne and address of person who completed cause of deeth (Item 23 | Ba) (Type, Print) | TRY IN. BET | HESDA, MD. Zeri |
| | State | 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature | 7 | 1 -11 | -14104).00.00(1 |

prome to joseph

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 2000 Month **Physician** 27, ELSIE GRAHAM Jan. 7:00 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SOUTHERN MARYLAND HOSPITAL CLINTON Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F 577-32-1033 YIS Director 83 Washington, D.C. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Director Maryland Prince George's Clinton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify à 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private Elementary/Secondary (0-12) College (1-4or 5+) Georgetown Univ. Hospital Housekeeping 6 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) 8 Sarah Powell Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon McKay - Niece 3716 Ely Place, S.E., #301, Washington, D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel Irom State permit. Pege Department of Important: If eny Injury or once. 4 Donation 5 Dother (Specify) Lincoln Cemetery 2/4/2000 Brentwood, MD 21. Signature of Funeral Service Lice 22. Name and Address of Fecility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, C. 23a. Ph/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, book, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical m Examiner Due to (or as a conse Examiner Ame Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uge contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings aveilable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yeş 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, tarm, street, lectory, office building, etc. (Specify)

The lew requires that the death certificate be executed P.O. Box 68760, Records. Division of Vital or Attending Physicien:

physician s the buriel

signed by the

page 2

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After

the Marylend

21215-0020

Baitimore, Maryland

Show

"natural", or Name 23s or 28s-f show

Peges 1 and 2 should be filed within 72 hours effer enert of Heelin and Mental Hygiene.
Intel filem 27 is marked other than "natural", or fles inty of other traumide event, the leader.

death. efter death Director: To the Hospital or Atter within 24 hours efter des To the Funeral Director completely filled in by th

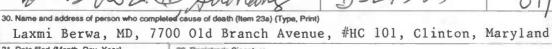
DHMH 16 Rev 6/95

State

29b. Signature and title of certifier

4 Homicide

29a, Certifier



32. Blegistrer'a Signature

Registrar

edical

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c, License number

29d. Date signed (Month, Day, Year)

20735

2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** Daniel Ginn Garner 4,2000 February 8:00PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 11500 St. Mary's Church Road Charlotte Hall Charles If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6.Sex Xxx M 2□F **Funeral** Yrs. 212-54-5859 51 24,1948 Washington DO Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. insida City Limits ttem 27 is marked other than "natural", or items 23s or 25s-f show other traumetic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Charles Charlotte Hall 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ferma 23a eny Injury or other traumatic avent, the Medical Examinations. 11500 St. Mary's Church Rd. 20622 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14 Reca - American Indian Bleck, White, etc. 1 Never Married Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Truck Driver Electric 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) James Heber Garner, Jr. Anna M. Racey Garner 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6 2 2 19e. Informent's Neme/Reletionship (Type, Print) 20b. Place of Disposition (Name of cametery, cremetory or other place)

Church Rd. Charlotte Hall 20c. Location - City or Town, State Elizabeth Garner/Wife Baltimore, 20e. Method of Disposition 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) St. Mary's Newport 2/8/00 Charlotte Hall, MD. 22. Name and Address of Fecility 21. Signeture of Funerel Service Licensee AREHART-ECHOLS FUNERAL HOME.P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

20646

Approximate Interval Between Onset end Death **Physician** immediate Cause (Finel disease or condition resulting in deeth) /Medical Lung Cancer with metatasis to liver and brain Examiner Due to (or es a consequence of): Examiner certificate be executed sician and bunel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or es e consequence of) USB BS signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown p 24b. Were autopsy findings avellable prior to completion of cause of death? Completed 24a. Wes en eutopsy peen page 2 has certificate 1 ☐ Yes 2 1 No 1 TYAS 2 No or Attending Physician: funeral director, 26. Place of Deeth (Check only one) Be 25. Wes case referred to medical exeminer? Other: 4 Nursing HomeX X Residence 8 Other (Specify) 1 ☐ Yes 2 🕅 🗙 O Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After XXNeturel 5 Pending efter deeth. 1 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital of 24 hours e Funeral D XX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 29e. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and menner stated. To the Within 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D28352 February 7, 2000 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar

State

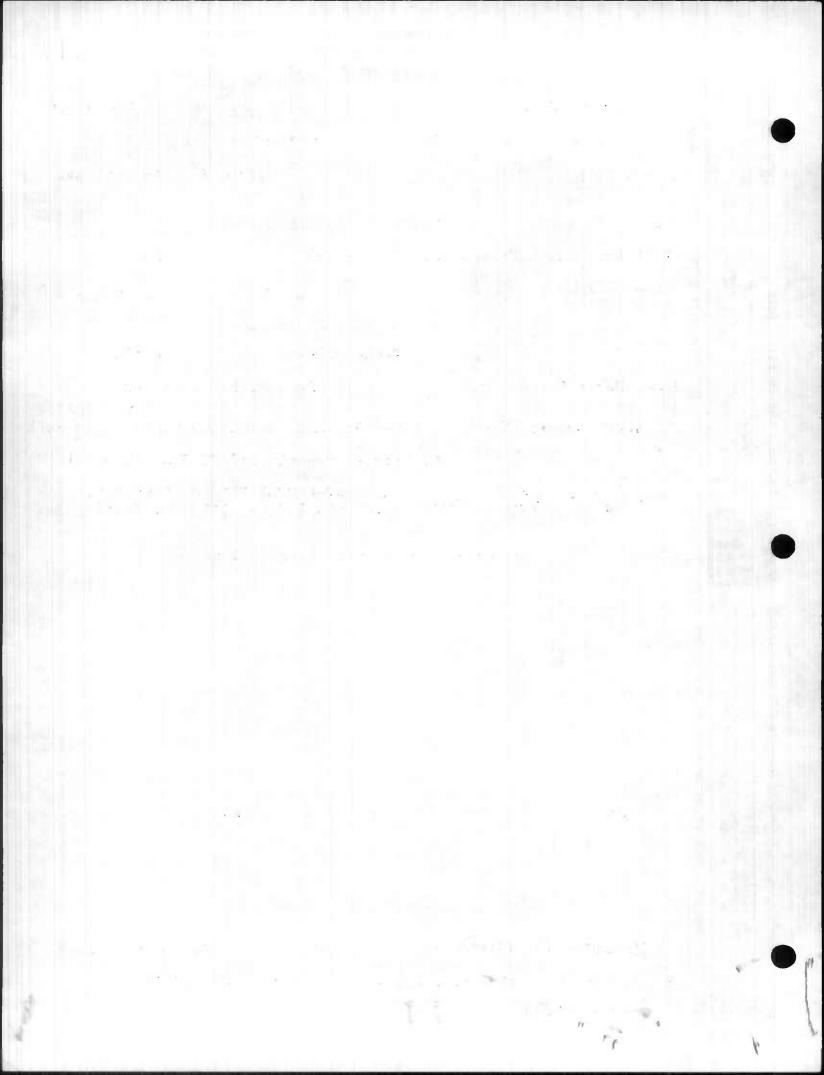
31. Date filed (Month, Day, Year) FEB 0 7 2000

32. Registrer's Signeture

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD

B. Sporks

20646



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 05 1 18

| | | | | | | Certifica | ate of | Death | F | Reg. No. | 00 | 110 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------|----------------------------------------|---------------------------|-----------------------------------------------------|-------------------------------------------|---------------------------|--------------------------------------------|-----------------------------------------------------------|
| п | Sh t . i | | 1. Decedent's Nama (First, Middle, Las | * | | | | | 2. Data of Dea | ith | | 3. Tima of Death |
| | Physici /Medi | | Emma Elizab | oeth Hash | | | | | Februa | ry 1, 2 | Year 000 | 3:15 AM |
| | Examir | | 4e. Facility Name (If not institution, give | street end number) | | | | 4b. City, Town, or L | | - | | |
| | | | Hart Heritage Est | tate | | | | Street | | Н | arford | |
| | Funeral Director | | 5. Social Sacurity Number 6. S | | a (In yrs. last I | Yrs. If Un Month | der 1 Yaar hs Days | | 8. Data of Birth (Month, De) Oct. 2 | r, Year) | 9. Birthplac Country Penns | ylvania |
| | yland | | 10e. Stete 10b. County | | 10c. City, To | wn or Location | | - | | | 10d. | insida City Limits |
| | Mer Mer | ctor | Maryland Harfor | rd | | Bel Air | | | | | | 1 ☐ Yes 2 ◯XNo |
| | th th | Director | 10e. Street and Number | | | | Zip Coda | | | 10g. Citizen of | What Country | ? |
| | 23a | | 509 Country Wall | k Court | | | 210 | 15 | | USA | | |
| 020 | 72 hours after death with the Meryland "netural", or items 23s or 28s-f show oldest Examiner must be notified at | by Funeral | 11. Merital Status 1 □ Never Married 2 □ Merried 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yas, Giva Yaar or Datas: | Ever In U,S. | | cedant of I pecify Cub | Hispanic Origin? (Spen, Maxican, Puarto Specify: | pecify Yas or No- Plican, etc.) | 14. Rec Bla Specifi | ce - Amarican ck, Whita, etc. y: Whi | |
| 5-0 | 72 ho | eted | 15. Decedant's Ed (Specify only highest gra- | ucation | 16 | a. Decedant's U | sual Occup | pation during most of word | kina | 16b. Kind of B | usinass/indus | ity |
| Maryland 21215-0020 | within ene. then | Completed | Elemantary/Secondary (0-12) | College (1-4or 5 | | | | during most of world) | Wing . | | s Ange Gover | |
| D | H Charles | | 12 17. Fathar's Nama (First, Middla, Last) | | 5 | ecretar | У | 18. Mothar's Nam | na (First, Middla, | - | | |
| ian | S a b | To Be | William Aaron M | attis | | | | Beatrice | | Kaise | , | |
| ary | E SEE | - | 19e. Informant's Name/Raiationship (7 | | 15 | b. Mailing Addr | aas (Street | and Number or Ru | (30,700) | | | de) |
| | | | Phillip G. Senesch | hal / Son | 5 | 09 Coun | try W | alk Court | , Bel A | ir, MD | 21015 | |
| ore, | of Heal Item 2 other | | 20a. Mathod of Disposition | | 20b. Piace | of Disposition (/ ery, crematory of | Vame of | cel | Data | 20c. Location | City or Town, | State |
| E | Page net c nrt: If rry or | | 1 ☐ Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | op Serv | | | 2-2-00 | Towson, | Marvl | and |
| Baltimore, | pemit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other sncs. | | 21. Signetura of Funerei Sarvice Licani | see / | 11,2.3.3.6 | 22. Nama | and Addre | ess of Fecility | | | · miji | - |
| m | 88 E 8 8 | | Atinh (1) | Much | | | | uneral Ho sbury Roa | | | arri an | a 21000 |
| H | | Н | 23a. Part Finant tha disaasa, or comp shock, or haert failure. List only of | lications that caused | tha death. De | not antar tha m | noda of dyl | ng, such as cardlac | or raspiratory an | reat, | Ap | proximata |
| v | Physician | | SHOCK, OF HABIT RAILUTE. EIST OTHY | oria cardsa ori alacri ilii | | | | | | | | arval Batween naat and Death |
| d | /Medical | | Immediate Causa (Final diseasa or condition | ** | (e | re bral | UAS | scular | LISEA | se | 1000 11 | YEARS |
| В | Examiner | | rasulting in death) | a | Due to (or es | consequence of | of): | | | | | |
| | pe sit | lue | | b | | | | | | | i | |
| | ate produced months the buriel-transit | Examiner | Sequentially list conditions, if eny, leading to immediate | | Due to (or as a | consequence | of): | | | | | |
| 68760 | Dallo | | causa. Entar UnderlyIng Causa (Disaasa or Injury that Initiated evants | c | | | | | | | i | |
| 89 | certificate nding pro- | Medical | rasulting in death) Last | L | Jua to (or as a | consequence o | ot): | | | | | |
| Box | eath cert attending I for use | | | d | | | | | | | | |
| m . | death e atter | cla | Part II. Other eignificant conditions co | atributing to death bu | t not resulting | in the underlying | a cause ab | ven in Dert I | 23h Did to | obacco usa co | ntelbute to th | e cause of death? |
| P.O. | the by the | Physician/ | | | t flot facetting | in the underlying | a canno a | von in Port 1. | | | | ly 4 Ninknown |
| | s that gned b | by F | | | | | | | | | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| of Vital Records, | e law requires that the de has been signed by the a je 2 should be detached | Completed | | | | | | | 24e. Was a perfor | n eutopsy med? | availal compl of dea | eutopsy findinga ble prior to etion of cause th? |
| <u>e</u> | E Sag | | | | | | | | 1 🗆 Y | as ZXNo | 1 🗆 Yı | aa 2□ No |
| \frac{1}{5} | Physician: The | Be | 25. Was case referred to medical axaminar? | Hospital: | | | 0 | 26. Placa of Dea | | | Assi | SKI |
| ō | this aldi | . To | 1 Yas 2 No | 1 LI Inpatier | | utpatient 3 Time of | DUA | | oma 5 ☐ Rasid | | | CARL |
| הס | After fune | tion | 1 Satural 5 Panding | 28a. Data of Injury (Month, Day | Year) | injury M | 28c. Inju Wo | rk? Yas 2 □ No | 260. Describe II | ow injury occur | rea | |
| Division | To the Hospital or Attending Physician: white 24 hours after deals are after deals To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: | 2 Accident invastigation 3 Suicide 6 Could not be dataminad | 28e. Piace of Injubuilding, atc. | ry - At homa, (Specify) | | | 140 2010 | 28f. Location (S City or Town | | per or Rural Ro | oute Number, |
| | To the Hospital within 24 hours a To the Funeral I completely filled | edical | 29a. Certifier (Check only one) | eiclan: To the best of iner: On the basis of | axamination a | e, daath occurre nd/or invastigati | ed at the ti | ma, data and placa, opinion, daath occur | and due to the c red at tha tima, d | auaa(s) and mi | annar as state and dua to the | d. causa(s) |
| | the the | Med | 29b. Signatura and title-of certifiar | and mannar stet | ed. | | 29c. Licans | | | | | |
| | 8 4 8 4 | | | · M^ | | 1 | | - | 1 | 9d. Data signe | | |
| | | | 1 01111/8 | - / -/ 3 | | | | 38889 | | FreB | 1/20 | - |
| | 12 | | 30. Name and address of person who c | ompleted causa of da | ath (Item 23a) | (Type, Print) MBCPA | troil | Bela.n | MS. | 2104 | | |
| | Sta Begistr | | 31. Dete filed (Month, Day, Year) | Registra | r's Signature | 6 1 | | | | | | |

Sant.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) FEBRUARY 7 ACT 4:00 AM Hamilton M. ILEN 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 6300 South Ostume If Under 1 Year | Munder 24 Hrs. 8. Date of Birth | Hours | Min. (Month, Dey, Year) Osbune Birthpiace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 1 M 2 F Months 3-40-9762 Yrs. MARYIANO FEBRUACY 14, 1913 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Macyland PRINCE Upper Marlboro GEORGE 10g. Citizen of What Country? 10f. Zip Code ShorNE Rd 1.S.A 20772 6300 South (12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Maritel Status 1 Never Memied 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 □ Divorced 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER Domestic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) MARTHA FOEDES Tichned TORC 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) heltenham Rd. Upper Marlboro MD 20772 Name of Date 20c. Location - City or Town, State WENCY FORM / DAUGHTE 20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ Removel from State 11591 Daughter 20b. Plece of Disposition (Neme of cometery, cremetory or other piece) surrection Cem. Feb. 10,2000 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Lyferal Sewice Lice 22. Name end Address of Facility Adams Funeral Home P.A. Aguasco, MD 20608 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Hypertension Due to (or as a consequence of): Dementia Due to (or as a consequence of): tremous enal 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 70 3 Probably 4 Unknown hyperlipidemin 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 10 No 1 ☐ Yes 2 ☐ No

Physician /Medicai Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Directo

Funerai

by

Completed

Be

2

Funeral

Director

th and Mental hygiene. 7 is marked other than "natural", or items 23a or 28a-1 show trsumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Examina. page.

Baltimore, Maryland 21215-0020

death with the Maryland

Physician/Medical Examiner attending physician and for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last been signed by the should be detached

þ

Completed

Be

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Certification:

edicai

page 2 s has

certificate

24 hours after death.

Funerel Director: After this certific letaly filled in by the funeral director,

or Attending Physician:

Hospital

To the Hosp within 24 hou To the Fune completaly fi

25. Was cese referred to medical examiner? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Dey Year) 5 Pending Investigation

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

5 Residence 6 Other (Specify)

29a. Certifier (Check only one)

1 ☐ Yes Z No

27. Menner of Deeth

Natural

2 Accident

3 ☐ Sulcide

4 T Homicide

15d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mennar as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signefure end title of certifie Holle 6.

D42049

29d. Date signed (Month, Day, Year) 2000

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Alain. G. CHAMPALOUX MID.

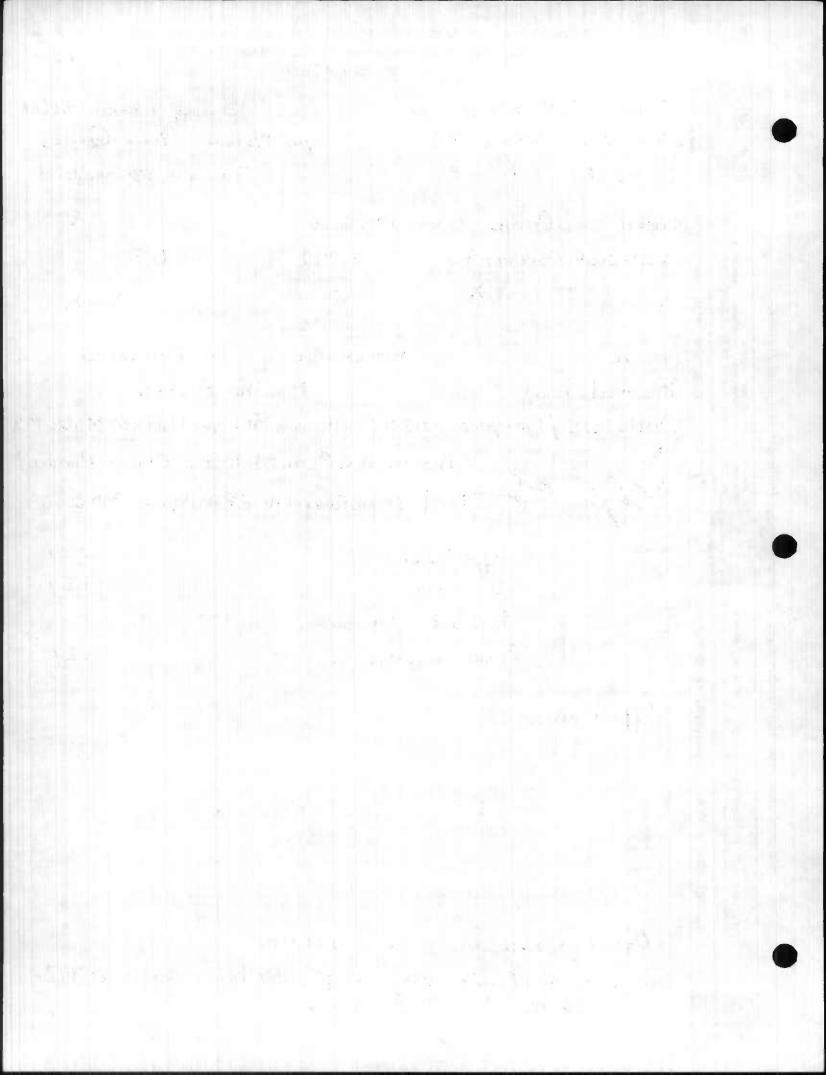
Upper MARIBONS

20772-MD

State Registrar

6 Could not be determined

32. Repistrar's Signature

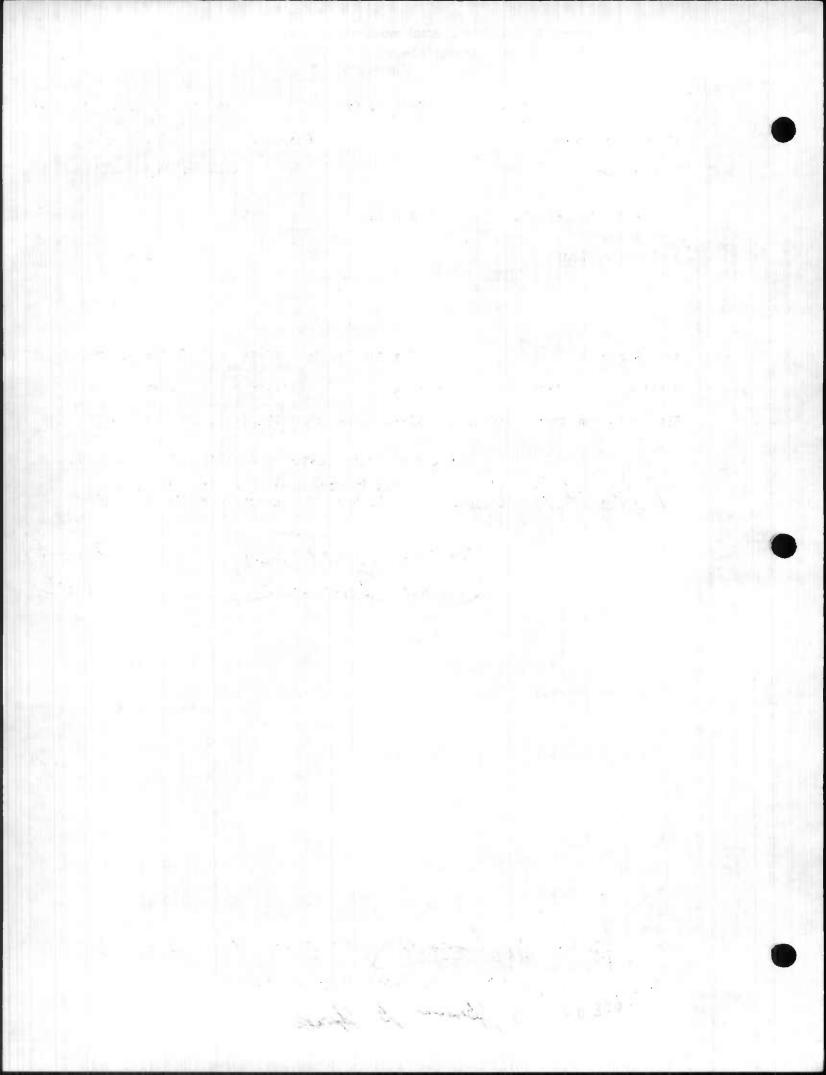


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 05 120 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29, 2000 **Physician** 6:45 AM Paul Anthony Hewitt, Sr. January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 37575 Manor Road Chaptico St. Marv's 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours 217-72-9486 Yrs August 28, 1956 Maryland **Director** 43 Usuei Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Example: must be notified at 1 Yes 2 No St. Mary's Chaptico Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37575 Manor Road 20621 II S A permit. Pages 1 and 2 should be liled within 72 hours after death v Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a ent injury or other traumatic event, the Medical Examinet mustle Funeral 14. Raca - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondery (0-12) Coilege (1-4or 5+) 12th Grade Tractor Trailer Driver Trucking Company 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Hewitt Ellen Hill William Franklin Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37575 Manor Road, Chaptico, Maryland 20621 Elizabeth Ann Hewitt (Spouse) 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriei 2 □ Cremetion 3 □ Removal from State 2/2/2000 Helen, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Queen of Peace Cemetery Mattingley-Gardiner Funeral Home, P.A. 21, Signature of Funeral Service P.O. Box 270, Leonardtown, Maryland 20650 nouner ULKERREX 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) runn Examiner Examiner no The law requires that the death certificate be executed physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that Initiated events resulting in death) Last (or as a nquence of) Division of Vital Records. P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) 957 ō signed by the a 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to should 24e. Wes en eutopsy Completed completion of cause NA s certificata has t director, page 2 s 1 Yes 2 No 1 TYes 2 No or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 □ Nursing Home 5 ■ Residenca 6 □ Other (Specify) Certification: To 1 TYes 2 D No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Neturei 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Roufe Number, City or Town, State) 28e. Piace of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 🎏 Csrtifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. within 2 29b. Signature and life of certifie 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23e) (Type, Pr M D Hollywood, Maryland 20636 atrick Jarbøe/, 31. Date filed Month Pay, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

un

Registrar



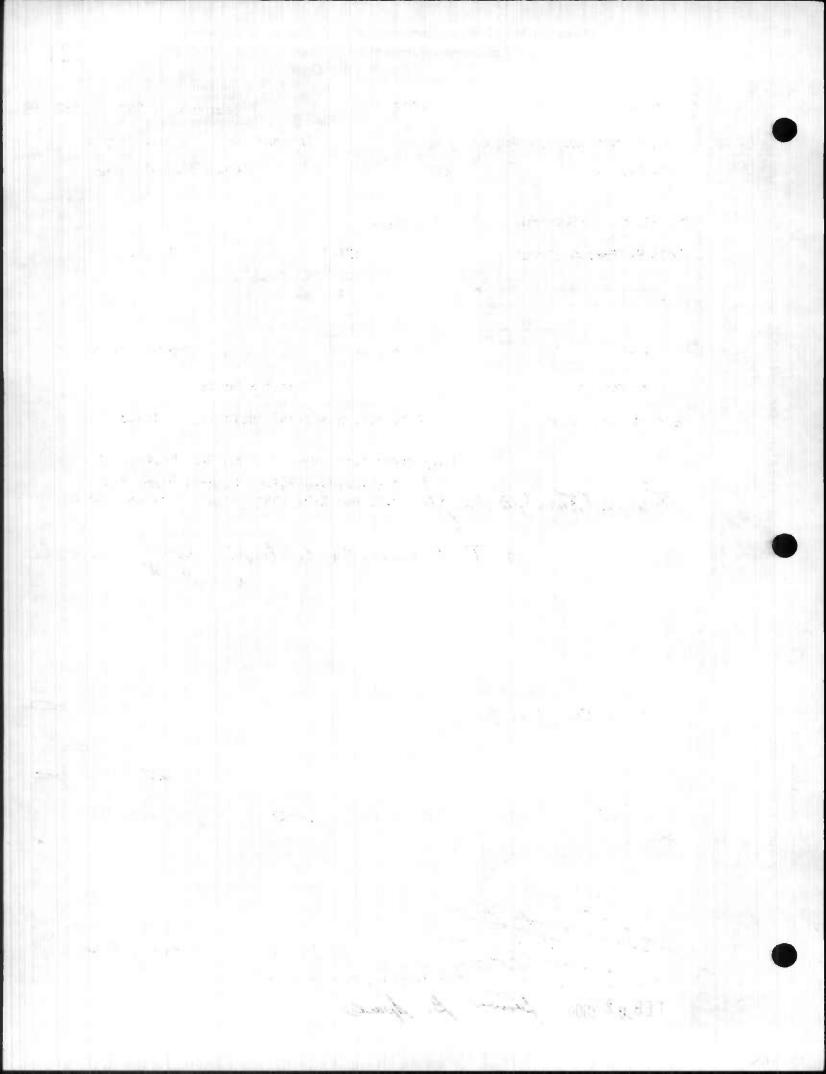
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month Physician Hood Leonora 5:25 PM February 1, 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown H Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. 0ctober 30, 1911 Birthplece (State or Foreign Country)
 Texas 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Months 204-38-2564 88 Yrs. Director Usuei Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "patural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examination and interest and interes 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Pennsylvania Philadelphia Philadelphia 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 19128 U.S.A. 7214 Hill Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1□ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Ticket Maker Department Store 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Ophelia Snyder Karl Hornig 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Neme/Relationship (Type, Print) 7214 Hill Road, Philadelphia, PA 19128 Edward Hood (son) 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 2/5/2000 Yeadon, PA 4 Donation 5 Other (Specify) Holy Cross Cemetery 22. Name and Address of Fecility. Mattingley-Gardiner Funeral Home, P.A. Funeral Service Licanses P.O. Box 270, Leonardtown, Maryland 20650 even Ridere 23e. Pert1. Enter the disease or complications that caused the milh. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical CerebroVasculor Examiner Ainden Due to (or as a consequenca of) Examiner attending physician end for use es the buriel-trensit The lew requires that the deeth certificate be executed Sequentially tist conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a 23b. Did tobacco use contribute to the cause of death? abites Milletus 1 Yee 2 No 3 Probably been signed by should be detec þ 24b. Were autopsy findings available prior to completion of cause of death? Completed pege 2 this certificate Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Naterai n 24 hours after death.

Ne Funeral Director: Al 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide ŏ Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated.

— Medical Examtner: On the best of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only 290. Signature and title of certific 29d. Date signed (Month, Dey, Year) 00 rse of deet (Item 23e) (Type, Print) James C. California, Maryland 20619 Bøyd, MD FEB 8 Registrar's Signature State Registrar **DHMH 16 Rev 6/95**

6 um

Leonora Hood

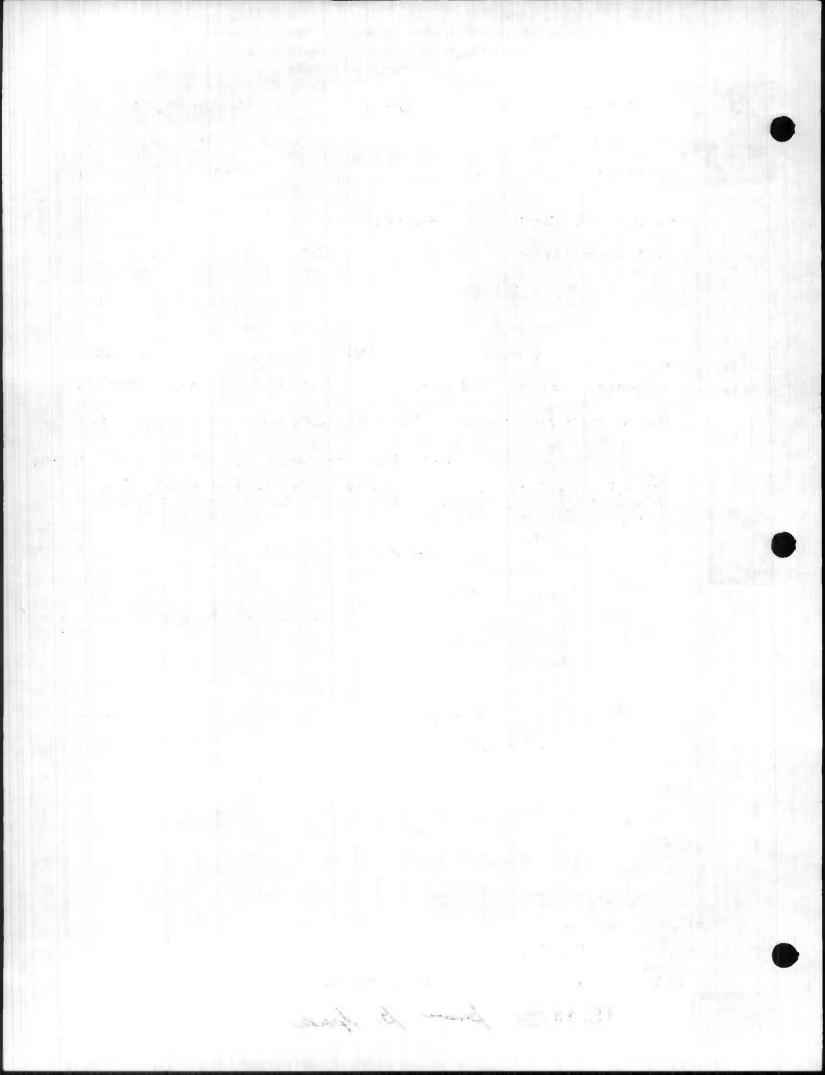


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State of Maryland / Department of Health and Mental Hygien 0 05 1 2 2

| | | | | | Cei | rtificate of | Death | | Reg | j. No. | 00 | (, 6, |
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| 2 | | 1. Decedent's Nama (First, Middle, La | ist) | | | | | 2. | Data of Death Month | Day | Year | 3. Time of Death |
| Physicia /Medic | | William | Handy | / | Hayı | man | | F | ebruary | | 00 | 7:37 AM |
| Examin | _ | 4a Facility Nama (If not Institution, gir | a street and number, |) | | | 4b. City, Tov | vn, or Local | tion of Death | 4c. County | of Death | |
| /4L | | 27921 Rectory C | ourt | | | | Mech | anics | ville | St. | Mary | ' S |
| Funeral Director | | | Sex 7. A 1 M 2 □ F 6 | ge (In yrs. last b | oirthday) Yrs. | If Undar 1 Yaa Months Days | r If Under 2 Hours | Min. NC | Date of Birth (Month, Day, 12) (Nember 1) | (par) 1932 | Coun | lace (State or Foreign try) y l a nd |
| and w | 1 | 10a. State 10b. County | | 10c. City, To | wn or Lo | cation | | | | | 10 | Od. Inaide City Limits |
| the Mary 28a-f sho | ector | Maryland St. M | ary's | Med | chan | icsville | | | 100 | . Citizan of W | Vhat Coun | 1 ☐ Yes 2 💆 No |
| ath with | Funeral Director | 27921 Rectory C | _ | | | 20 | 659 | | | USA | 1 | |
| Ind 21215-0020 be filed within 72 hours after death with the Maryland tal Hygiane. d other than "neturel", or items 23s or 28s-f show event, the Madical Examiner must be notified at | by | 11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Armed Forces' 1 X Yas 2 HYes, Give Yaar or Datas: | ? | | Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🔀 No | | Puarto Ric | y vas or No- | | e - Americ k, White, | |
| Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours af Department of Health and Mental Hygians. In important: If item 271s marked other than "naturelt, or any Injury or other traumatic event, the Medical Enamples. | Completed | 15. Decedent's E (Specify only highest grant properties) Elementery/Secondary (0-12) | | | (Give | dent's Usual Occu kind of work done DO NOT use retin | e durina most | of working | 16 | 6b. Kind of Bu | | |
| Nogier th | | | 8 years | | | Doctor | | | | JUNEAU TO STATE OF THE PARTY OF | oprac | tic |
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| should Ishould Ind Mend | 2 | | andy | Hayman | Ma. A 4 101- | - Address (Ct.) | | orie | A: | | Bull | |
| and 2 sl and 2 sl aaith am n 27 la n | | 19a. Informant's Name/Relationship Sharon Anne Hay | | se) 2 | 27921 | Rectory (| | echanic | csville, l | Maryland | 2065 | 9 |
| Baltimore, M emit. Pages 1 and 2 Department of Health 8 mportant: If feet 27 in iny Injury or other tra | | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | | cemet | lery, crer | sition (Name of matory or other pl itan Crer | | 1 | | Alexan | | wn, State , Virginia |
| Baltim permit. Pa Departman important any Injury | | 21. Signature of Funeral Service Lice | Larde | ner | Ma P. | Name and Additingley | ress of Facility y-Gardi 270, Le | iner I | Funeral dtown, N | Home, | P.A. | 0650 |
| Physician /Medical Examiner | | 23a. Part1. Enter the disease, or don shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | ona causa on aach I | ina. | | - | | | | | ^ | Approximate Interval Batween Onsat and Death Minuff Hours Lows Manual |
| 2 % | ine | | , (h | DNIC | | obsta | che | 1 | | | 1 | nous |
| ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse, (Disease or Injury that initiated events resulting in death) Last | с. | Due to (or as a | | | In o. | Nes | Dis | ease | 1 | 5 nonth |
| Box lath certification attending for use a | 2 | | d | | | | | | | | | |
| cords, P.O. Box 6: v requires that the death certific been signed by the attending p should be detached for use as | by Physician/ | Part II. Other significant conditions of | | | | | | -50 | | acco use cor | 3 Prot | the cause of death? |
| Division of Vital Records, to attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be at the page of the funeral director. | Completed b | prob. ble | cotomy | | | | | | 24a. Was an performe | autopsy ed? | ava | era autopsy findings allable prior to mplation of causa death? |
| Vital Relevicion: The law | EO | | | | | | | | 1 ☐ Yes | 2DINO | 10 | Yas 2□ No |
| ita In: | Bec | 25. Was case referred to medical | | | | | 26. Place | of Deeth (6 | Check only one) | - | | |
| of Vita Physician: this cartific al director, | 70 | examiner? 1 ☐ Yes 2 ☑ No | Hospital: | ent 2 ER/0 | Outpatier | nt 3 DOA | ther: 4 🗆 Nur | rsing Home | 5 Residen | ce 6 Oth | er (Specif | 1) |
| Division of Vita vithe Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. | Certification: | 27. Manner of Beeth 1 Netural 5 Pending 2 Accident Invastigation | | ury 28b | Time of Injury | W | uryat ork? ⊒Yes 2⊡N | No | d. Describe how | | | |
| DIVIS all or All s after de la Directe de la | Certific | 3 Suicide 6 Could not be determined | 28e. Place of In building, e | jury - At home, tc. (Specify) | farm, str | reet, factory, office | 9 | 281 | f. Location (Stre City or Town, | et and Numb Stere) | er or Rura | i Route Number, |
| To the Hospital or within 24 hours afte to the Funeral Dir. complately filled in | edical | 29a. Certifier (Check only one) 1 Certifying Pl | nysicten: To the best minar: On the basis of and manner s | f examination a | ge, death and/or in | n occurred at the vestigation, in my | time, date and opinion, daat | d piece, end h occurred | d due to the cau at the time, date | se(s) and ma e and plece, | nner as st and due to | ated. the cause(s) |
| To the within com | Σ | 29b. Signature and title of certifier | w | | | | nsa number | .06 | 290 | d. Data signed | | Day, Year) |
| 6 pm | | 30. Name and address of person who Kiran D. Mehta | completed cause of | | | Print) Marylan | id 2063 | 36 | | | | 1 310 |
| Sta Registra | | 31. Date filed (Month, Day, Year) | | rar's Signature | | 9. Spo | | | | | | |

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0107 24 CHARLES BREASE 2000 January HILL /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Pallston Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) 4/24/1928 **Funeral** XXM 2DF 220-24-7465 MAryland **Director** Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits must be notified at 1 Yes 25 No PA York Delta Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 S. Oak Heights Trail USA itema 23a 17314 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☐ KNo
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married 0 altimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: White by 3 ☐ Widowed ♣☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "nationally injury or other traumatic avent, the marked page. Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Transportation 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Floyd Μ. Hill Frances May Walton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t9a. Informent's Neme/Reletionship (Type, Print) Dorothy M. Barrett-companion 110 S. Oak Heights Trail, Delta, PA 17314 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial **20**Cremetion 3 ☐ Removel from State Evans Eagle Crematory 1/25/00 4 ☐ Donation 5 ☐ Other (Specify) Leola, PA 21. Signature of Funeral Service Licanse 22. Neme end Address of Facility Harkins F.H.Inc., 600 Main St., Delta, PA cause on each line. 17314 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finei Respiratory failure DYXS. disease or condition resulting in death) Examiner Severe Chronic obstructive fulumonary Disease Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): 3415. Fibrillation. Atrial Physician/Medical Due to (or es a consequence of): Cardio - Respiratory Arrest. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Vital Records, by 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 21XN0 1 Yes 2 0 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Naturel 5 Pending investigation n 24 hours after death.

• Funeral Director: Alt pletely filled in by the fur t □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

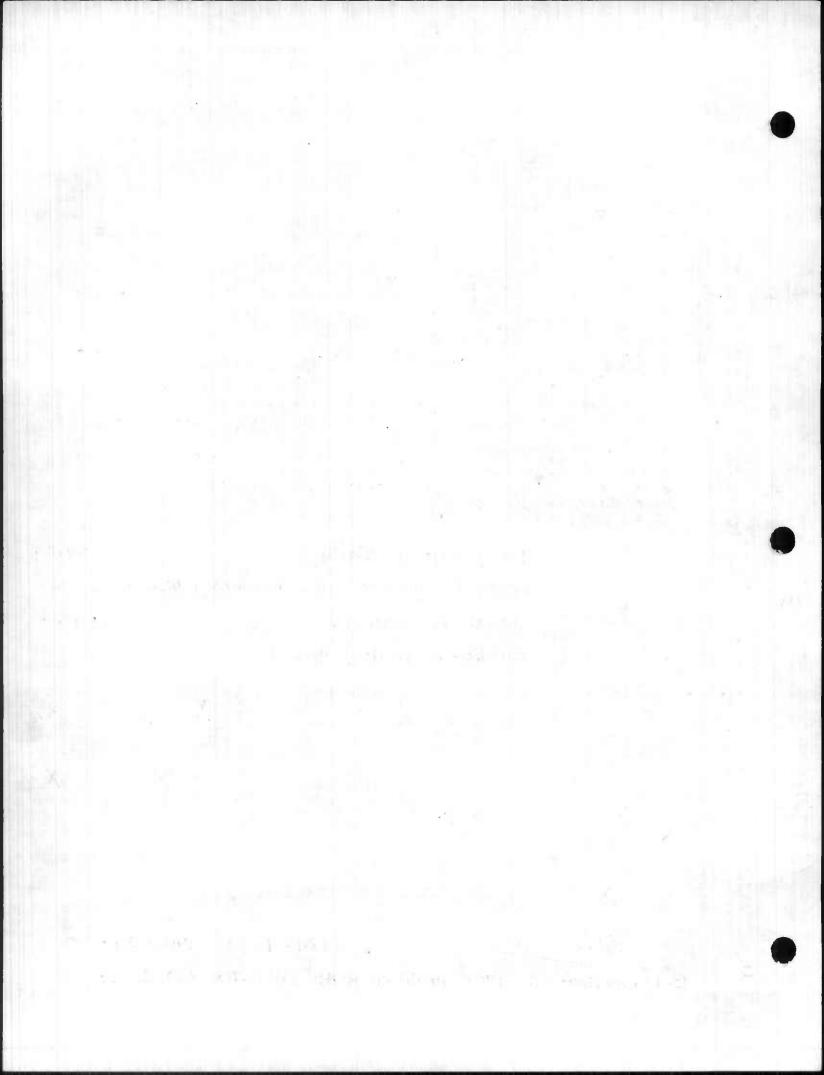
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of prillies 29c. License number 29d. Dete signed (Month, Day, Year) JAN - 24 - 00 D18424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FALLSTON MD. 21047 13. D. PAREKHMD 1908 ROAD HARFORD

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State Registrar 31. Dete filed (Month, Dey, Year)

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32. Registrar's Signeture

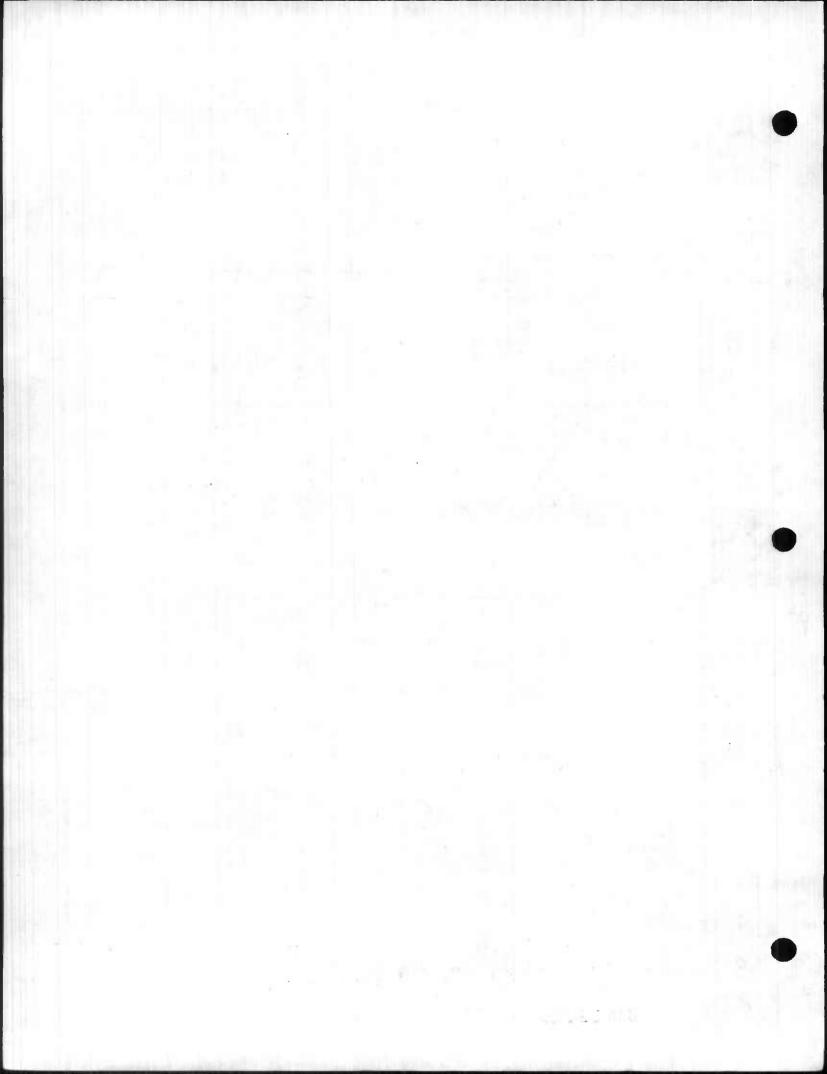


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** 1940 January Phillip James Hawthorne 15 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford 8. Dete of Birth (Month, Day, Year)
Jan. 15, 1939 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□ F Months Hours Alabama 417-48-9046 Director 61 Usual Residence of Deceden 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 25a-f show 1 No 2 No Directo Harford Aberdeen 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 "natural", or flame 25a 131 Hanover Street Apt. A 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (∑No If Yes, Giva Year or Dates: 14. Race - American Indian. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. filed within 72 hours after Hygiene. Cher then "naturel", or the 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Papes 1 and 2 ahould be filled w Department of Health and Montal Hygien Important: if Nem 27 is marked other tha Disabled N/A 10 18. Mothar's Nema (First, Middle, Meiden Sumeme) 17 Father's Name (First Middle Last) Be Jessie Hawthorne Veora Coleman 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Clara Hawthorne (Wife) 131 Hanover Street, Apt. A, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Steta 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 1/20/00 Aberdeen, Maryland 21. Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one cause on each that. Aberdeen, Maryland 21001-3399 Approximata Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis Examine Dua to (or es e consequence of) Examine Pnevnonia attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by to 1 PYea 2 No 3 Probably 4 Unknown à 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen I 2 61 00 1 Yas 2 No Division of Vital i or Attending Physician: efter death. Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 26b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending 1 Tyes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide To the Hospital or A within 24 hours effar To the Funeral Directompletely filled in by edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the ceuse(s) and menner steted. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 17,2000 D35012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Ave. Bel Air, Md. 21014 J. Kevin Lynch m.D 31. Date filed (Month, Day, Year) 32/Registrar's Signature State JAN 1 9 2000 Registrar

James

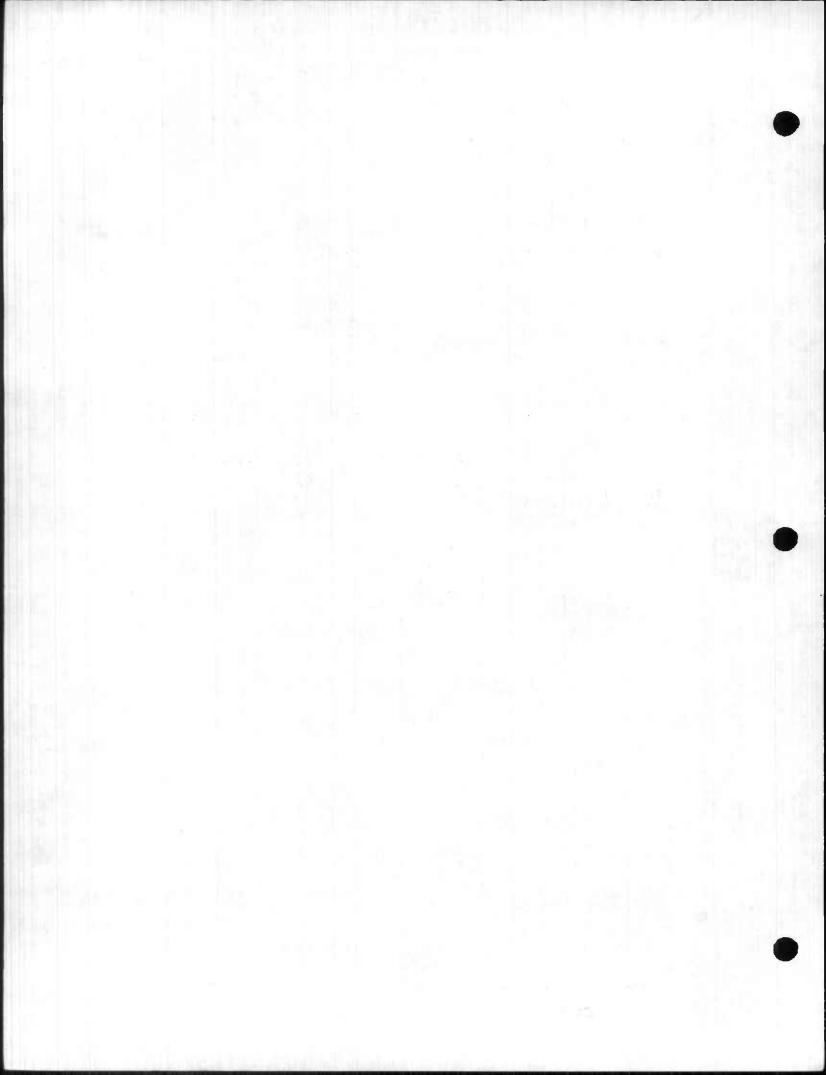
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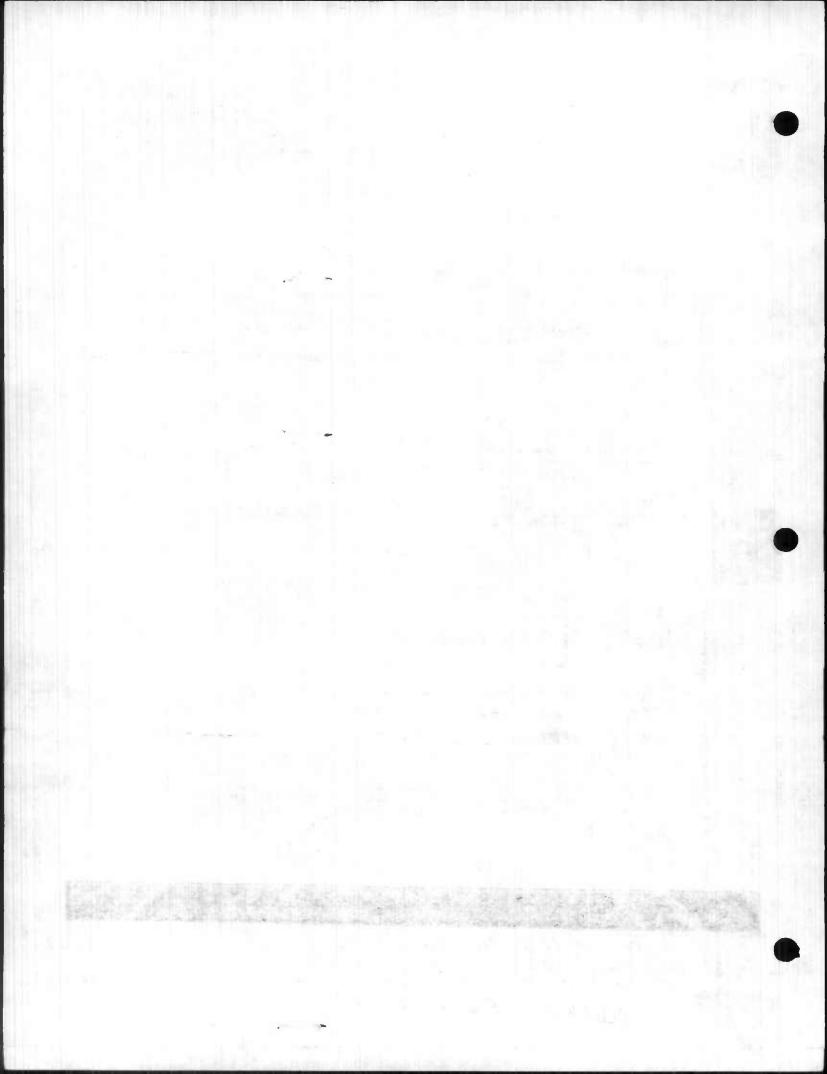
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ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 1, 2000 Hettenhouse 10:00 AM Marian 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Prince George's Regional Hospital Laurel Laurel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 22, 1914

8. Birthplace (State or Foreign County)
New York 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number Months Days Hours Min 1□M 2⊠F 577-46-4293 Usuai Residence of Decedent 10d. Inside City Limits 10b. Counts 10c. City, Town or Location 1X Yes 2 □ No Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 U.S.A. 4806 Hollywood Road 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specity: Specify: White 3 M Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 18. Mother'a Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Waldo Francis McNaught Edith Boyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2302 Montclair Court, Bloomington, Indiana 47401 George W. Hettenhouse - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State Fort Lincoln Cemetery 02/04/2000 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licent 4739 Baltimore Avenue, Hyattsville, MD 20781 Jum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsel end Death immediate Cause (Finel disease or condition resulting in deeth) LoBAR PREUTONIA

Due to (or as a consequence of): PULTIONARY DISEASE Chronic obsTRUCTIVE
Due to (or as a consequence ot): 1962 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last -23-00 ARDIAC ARRHYTHMIA 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings aveitable prior to 24e. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case reterred to medical examiner? 28. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the lime, date and placa, and due to the cause(s) and manner as atated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier useri Mo 2-1-00 V00

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10e. Slate

Director

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permit. Pages 1 and 2 should be filed within 72 hours aftar death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 2 er pinty or other treumetic event, the Medical Examiner must be nonce.

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Certification:

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3altimore, Maryland 21215-0020

or Attending Physician: Hospital

To the Hosp within 24 hou To the Fune completely fi

State Registrar

Azher Hussain, MD

29a. Certifier

4917 Edgewood Road 32 Registrar's Signature

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

And

College Park, MD

Jr. 630

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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| upidu | Elementary/Sec | | - | College (1- | 4or 5+) | 16a. Decedent's Usual Occupation (Giva kind of work done during most of life. DO NOT use retired) Electronic Engineer | | | | | | | | |
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| Maryland Prince 10e. Street and Number 5701 San Jua 11. Marital Status 1 Never Married Maryland 15. Decedenty only higher 15. Decedenty only higher 16. Street and Number 17. Decedenty only higher 18. Informant's Name/Relations 19. C. Janette H. 20a. Mathod of Disposition 1 Never Married 20a. Mathod of Disposition 1 Neurial 2 Cremation 4 Donetion 5 Other (S 21. Signature of Funeral Service 22. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | Pa. Informant's Name/Relationship (Type, Print) | | | | | | | | | | | | | |
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| - | Part II. Other sign 25. Was case refexaminer? 1 □ Yes 2 [27. Manner of De. 1 □ Accident 3 □ Suicide | erred to medical fives to Could determ | al Ho: | spital: 1 le le 28a. Dete o (Monti | Due to (Due to (Due to (ath but not reserved in Injury - At Ing., etc. (Special best of my knows is of examination). | or as a consector as | nt 3 DOA f 28c. If M 1 | Otherniury & Work? | 26. Place of Dea 4 Nursing H | 24a. Was parto 10 11 11 11 11 12 14a. Was parto 10 10 10 10 10 10 10 10 10 1 | Yes 2 No an autopsyormed? Yes 2 No ane) dence 6 Ott how injury occur (Street end Numi wn, State) cause(s) and m | 3 Pro 24b. Wall of the Conference of the Confer | deebly 4 Unker tere autopsy findin railable prior to implation of cause deeth? N/A | |
| - | Part II. Other sign 25. Was case refexaminer? 1 ☐ Yes 2 ☐ 27. Manner of Delta 1 ☐ Mainter 2 ☐ Accident 3 ☐ Suicide 4 ☐ Hornicide 29a. Certifier (Check only) | erred to medical Silo ath 5 Pendi invest 6 Could detern 1 Certifyi 2 Medical | al Hosing tigetion I not be mined ling Physic t Examine | spital: 1 in 1 28a. Dete of Month 28a. Plece buildin | Due to (Due to (Due to (ath but not reserved in Injury - At Ing., etc. (Special best of my knows is of examination). | or as a consector as | nt 3 DOA f 28c. If M 1 | Other niury & Work? I TYe | 26. Place of Dea 4 Nursing H at es 2 No | 24a. Was parto 10 11 11 11 11 12 14a. Was parto 10 10 10 10 10 10 10 10 10 1 | An autopsy primed? Yes 2 No none) dence 6 Ott how injury occur Street end Numi wm, State) cause(s) and m date end place, | 3 Pro 24b. Way cc of her (Special rred ber or Rur canner es s and due t | deeth? N/A 2 No | |
| Medical Certification: To Be Completed by Physician/Medical Examin | 25. Was case reference warminer? 1 Yes 2 27. Manner of De. 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) | erred to medical Silo ath 5 Pendi invest 6 Could detern 1 Certifyi 2 Medical | al Hosing tigetion I not be mined ling Physic t Examine | spital: 1 in 1 28a. Dete of Month 28a. Plece buildin | Due to (Due to (Due to (ath but not reserved in Injury - At Ing., etc. (Special best of my knows is of examination). | or as a consector as | nt 3 DOA of 28c. If M 29c. Lice | ogiven Other Njury & Work? 1 Ye | 26. Place of Dea 4 Nursing H at as 2 No | 24a. Was parto 10 11 11 11 12 14a. Was parto 10 10 11 11 12 14a. Was parto 12 15 16 17 17 17 18 18 18 18 18 18 18 | Approximate to the cause of Death Prince George Geo | deeth? N/A 2 No | | |
| - | 25. Was case reference warminer? 1 Yes 2 27. Manner of De. 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) | erred to medical served to med | al Hosing tigetion I not be mined in Physic t Examine | spital: 1 I Ir 28a. Dete o (Month) 28e. Plece- buildin stan: To the Ir on the ba and mann | Due to (Due to (Due to (ath but not reserved in Injury - Athory of Injury - Injury | or as a consector as | nt 3 DOA 28c. If M 28c. If M 29c. Lice | ogiven Other Njury & Work? 1 Ye | 26. Place of Dea 4 Nursing H at es 2 No | 24a. Was parto 10 11 11 11 12 14a. Was parto 10 10 11 11 12 14a. Was parto 12 15 16 17 17 17 18 18 18 18 18 18 18 | | deeth? N/A 2 No | | |

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State of Maryland / Department of Health and Mental Hygiene 00 05 | 29

| | | | | Certifica | te of | Death | | Re | g. No. | | | |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------|--------------------------|----------------------------|----------------------------|---------------------------------------|---------------------------------------------|-----------------------------|---------------------------------------------------|----------------------------------|
| | 1. Decedent's Nema (First, Middla, La | st) | | | | | 2 | . Data of Death | | Maria | 3. Time | of Death |
| ysician | Ruth | Alberta | На | arvey | | |] | Month Februar | Dey v 4, 20 | Year 000 | 233 | 5 P |
| Medical aminer | 4e Facility Neme (If not institution, giv | e street and number) | | - | | 4b. City, To | | ifion of Death | 4c. County | | | |
| | 112 Red Toad | Road | | | | Nor | th Eas | st | Cec | íl | | |
| ral | 5. Social Security Number 6. S | | (In yrs. last birth | (Cody) | r 1 Yaar | If Undar | 24 Hrs. 8 | Date of Birth (Month, Dey, | | | ace (Stat | a or Foreign |
| or | 218-32-9021 Usual Residence of Decedent | □ M 20XF | 81 Y | rs. Months | Deys | Hours | | october | | | Delaw | |
| by Funeral Director | 10a. Stete 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Li | | | | |
| ctor | Maryland Cecil | | Elk N | Mills | | | | 1 🖾 | | | | |
| al Director | 10a. Street and Number 14 Frame Row | | | 10f. Zip Code 21920 | | | | | 10g. Citizen of Whet Country? United States | | | |
| Funeral | 11. Marifal Sfatus | 12. Was Decedent E | Was Decedent Ever in U.S. 13. Wes Deced If Yes, spec | | | | gin? (Speci | fy Yes or No- | | e - America ck, White, a | | |
| by | 1 ☐ Nevar Marriad 2 ☐ Merried 3 🖾 Widowed 4 ☐ Divorced | 1 Yes 2 N If Yes, Give Year or Dates: | 0 | If Yes, specify Cuban, Mexican, Puart 1 ☐ Yea 2 ☑ No Specify: | | | | can, orc., | Specify | | ite | |
| | 15. Decedent's E. (Specify only highest gra | | 16a. I | Decedent's Usu | el Occup | ation | t of working | 1 | 6b. Kind of Bu | siness/Ind | ustry | |
| Completed | Elementery/Secondary (0-12) | College (1-4or 5- | | | | | | | | 6 = 3 | | |
| 8 | 8 17. Father's Neme (First, Middle, Last, | 1 | Ca | Cafeteria worker | | | | | oard o | | cati | on |
| Be | | | 18. Mother's Neme | | | | | elderi Sumen | 6) | | | |
| 2 | John Buckingham | | | | | | | | | | | |
| | 19a. Informant'a Name/Relationship (| | Mailing Address (Street and Number or Rural Routa | | | | | | | | | |
| | Lorraine M. Crain | /Daughter | 1 | 14 Frame Row, Elk Mills | | | | | * | | | |
| | 20a. Method of Disposition 1 | | cemetery | cremetory or k Cemet | other ple | ce) | 2/ | | oc. Location - Jewark, | | | |
| any inji any inji | 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 | | | | | | | | | | | |
| Examiner i | Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Sep | Oue to (or as a co | onsequence of onsequence of | : | | del | | | | Onset an | id Deeth |
| by Physician/Medical | that initiated events resulting in death) Last Part II. Other aignificant conditions of | | | | a 20 No | | | ne of death? | | | | |
| Completed b | | | | | | | | 24a. Was an perform | | ava | re autops ilable prid npletion of death? | sy findings or to of cause |
| mo | | | | | | | | 1 Tes | 2 No | 10 | Yes 2 | .□ No |
| Bec | 25. Was case referred to medical | | | | | 26. Place | of Deeth (| Check only one | | | | |
| ToE | axaminar? | Hospitel: 1 Inpatier | t 2 ER/Out | patient 3 D | OA Oth | an an | | 5 Resider | | er (Specify | Cono | taken |
| | 27. Magner of Death 1 Natural 5 Pending 2 Accident Investigation | | Year) 28b. Ti | me of jury M | 28c. Injui Wor 1 🗌 | | 28 | d. Describe how | | | | |
| Certification: | 3 Suicida 6 Could not b 4 Homicide determined | 28e. Place of Inju building, etc. | ry - At home, ferr (Specify) | m, street, fecto | ry, office | | 28 | If. Location (Str. City or Town, | | er or Rural | Routa N | lumber, |
| edicai (| 29a. Certifier (Check only one) 1 Certifying Ph | ysician: To the best of niner: On the basis of and manner stef | examinetion and | death occurred for investigation | at the tir | me, date an pinion, dea | d plece, en th occurred | d due to the car I at the time, da | use(s) and ma te and place, | nner as sta and due to | nted. the caus | e(s) |
| × | 29b. Signeture and title of certifier | | | 29 | c. Licens | e number | | 29 | d. Dete signe | d (Month, E | Day, Year | r) |
| | I fui cevil ! | Lan MD | | | 104 | 823 | | | 2/7/ | 20 | D | |
| | 30. Name and address of person who | completed cause of de HSU 2 | ath (Item 23a) (T | ype, Print) | ma | in 8 | 4. | EICH | 2 / | 11 | 219 | 21 |
| State | 31. Date filed (Month, Day, Xeer) | Se 32. Registra | 's Signature | books | 1 | 4 | | -11-10 | _ / - / | . 4 | | _/ |

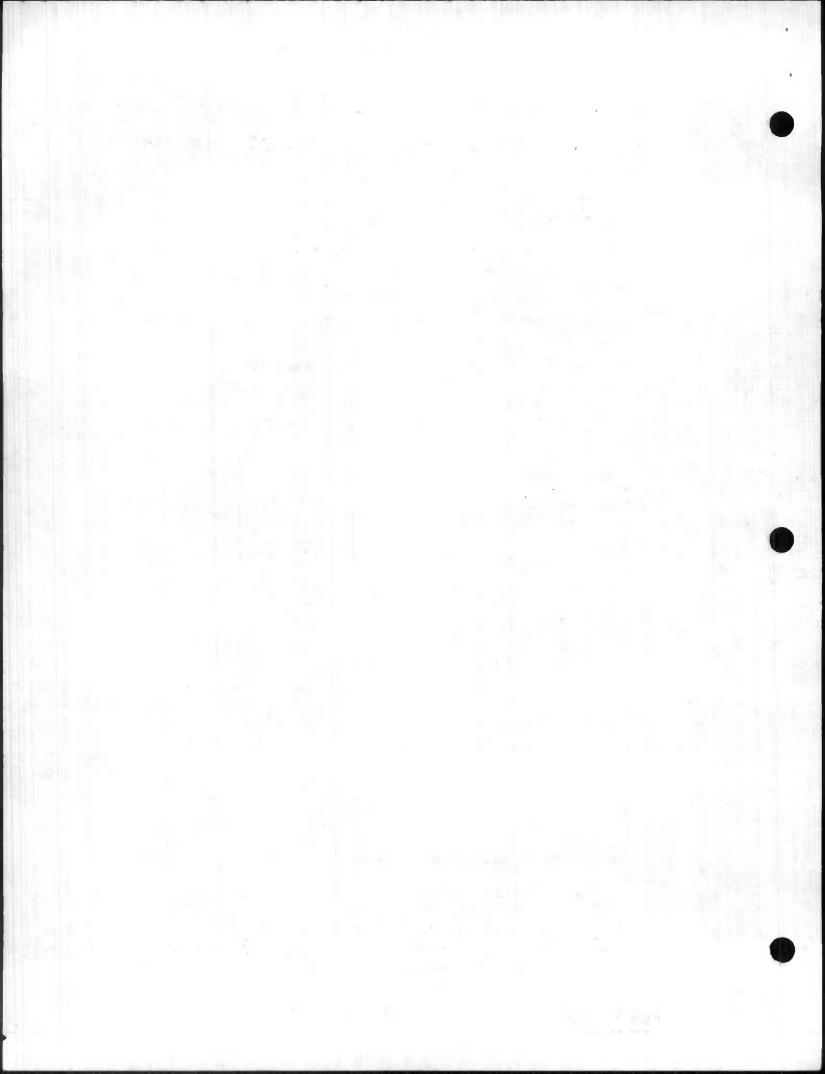
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. FEBFUMORY Y 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ANDREW HOWELL , 2000 2035 ACKSON /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner GENERAL HOSPITAL ALLSTON If Under 24 Hrs. 10 TRITOIA MO If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 10M 20 F 215-34-7504 Usual Residence of Dacedent Yrs. Director mo. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits na 23a or 28a-f ahow must be notified at HARFOIC 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10a Street and Number 10f. Zin Code "natural", or hams 23s or 1085 INTErs. RUN 2600 Funerai 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whita, etc. 1 Yas 2 No
If Yes, Give
Year or Datas: 1 Naver Married 2 Married 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiene. than Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Heelth and Mental Hygien important: If them 27 is marked other that any injury or other treasment. OWNER CLEANING 10 00 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be IRE GLENN HOWELL Jr (017 LORRAINE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William Howell-Brother Winters RUN RD. BelAir MO Jolla 2600 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition Date 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata AIr 4 ☐ Donation 5 ☐ Other (Specify) Belair menotial GARDENS 21. Signature of Funeral Service-License 22. Name end Address of Facility LUNCIAL everes 23a. Part1. Entar the disease, or compositions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Light only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel ANOYIC ENCEPHALO PATH DAYS diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): DAYS MYOCAUDIA(and Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DIABETES MEUITUS YEARS Physician/Medical Due to (or as a consequence of): YEARS KYPERTERSION 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown م Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peen s 1 Yes 2FINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Netural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 005120 FEBRUAKY 2,2000 30. Name and address of person who completed cause of death (light 23a) (Type, Print) 0 CEUNG BELASK PLUM TREE ROAD 104 31. Date filed (Month, Dey, Year) 32. Registrar's Signature FEB 0 7 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

05/3/ Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:06 AM James Arthur JANUARS 2000 Hall /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** Days Min. Months Hours Yrs. 231-16-4877 83 Director Sept. 30, 1916 Virginia Usual Residence of Decedent the Mendand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle flerns 23a or 28a-f short ner must be notified at 1 XYas 2 No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 12742 Hillmeade Station Drive 20720 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status naturel, or flen Black, Whita, etc. Amed Polices; 1 ☑ Yas 2 ☐ No If Yas, Giva Year or Dalas: WWII 72 hours effer 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Department of Health and Mental thygiene. Important: if item 27 Is marked other than *reny Injury or other traumatic event, the leastest. Elementary/Secondary (0-12) College (1-4or 5+) 6 Self Employed Carpenter 17. Father's Name (First Middle, Last) 18 Mother's Nema (First Middle Maiden Sumame) 8 Bluford Hall McDaniel Bessie 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 12742 Hillmeade Station Drive, Bowie, MD Kenneth R. Hall - Son 20720 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Buriat 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 102/04/2000 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD Q. Anitt 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPTIC SHOCK 2 HRS Examiner Examiner ACUTE ASPIRATION PNEUMONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician the buriel DYSPHAGIA Physician/Medical Due to (or as a consequence of) 80 ALCOITOLIC ENCEPHALOPATHY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PSYCHOSIS AND DEMENTIA þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed CHRONIC ALCOHOL ABUSE CORONARY ARTERY DISEASE 1 Yes 2 No 1 ☐ Yas 2 ☐ No ATHEROSCLEROTIC CARBIOVASCULAR DISEASE 25. Was case referred to medical axaminer? or Attending Physician: Be 26. Place of Death (Check only one) To 1 Yes 2 No Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours efter death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. edical completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 100 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier D31345 such , on 30/00 36. Name and address of person who completed causa of death (Item 23a) (Type, Print) NAPOLEON C. MARCELO, MD 4000 MITCHELLVILLE RD 8430 BOWIE, MO 20716 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State FEB 0 2 2000 Registrar

DHMH 16 Rev 6/95

21215-0020

Box 68760.

P.O.

Records,

Division of Vital

SER 5 2 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 05132 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Mildred Ethel Heess 11:58 p.m. January 31,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Hampton Health Care Frederick Frederick H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 7,1909 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days Hours 1 M 28 F Months 90 279-05-8877 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19506 Windsor Circle 21742 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Statue Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) manager savings and loan 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Surname) Clark B. Hunter Julia Katherine Six 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3003 Roderick Rd., Frederick, Md. 21704 Helen Clapp - niece 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 2-4-00 Rest Haven Cemetery Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death Carcinoma Lun Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? Heart for live 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to

Physician /Medical Examiner

physician and the burial-transit

signed to

certificate

To the Hospital or Atlanding Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

Certification: To

Medical

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

b

"natural", or herne 23a

Hied within 72 hours after Hygiene. Wher then "natural", or the

permit. Pages 1 and 2 should be flied with Department of Health and Mental Hygen important: If Nam 27 is marked other the any Injury or other traumedin avairs.

Baltimore, Maryland 21215-0020

Director

Funeral

À

Completed

Be

Examiner Physician/Medical þ Completed 8

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive

24e. Was an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of contin

29c. License number 29d. Date signed (Month, Dey, Year) D43091 2-1-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAERA

Tou House Ave, Frederich, MD 801 ZAIDI MA

State Registrar 31. Date filed (Month, Day, Year) FEB 0 3 2000 32. Registrer's Signature

The same and the same trans

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State of Maryland / Dep

| partment of Health and Mental | Hygiene | 0 | 1 | 5 | |
|-------------------------------|---------|---|---|---|---|
| ertificate of Death | | | 0 | | - |
| | | | | | |

| MICHAEL DWA | YNE HALL | | Cer | tificate of | Death | | Reg. No. | 00100 | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------|---------------------------------------------------|--------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------|--------|--|
| D 1 | 1. Decedent's Neme (First, Middle, Last | | | | | 2. Date of De Month | ath Dey | 3. Tima of De | eath | |
| Physician /Medical | Michael Dway | ne Hall | Jr. | | | JAN. | 22, 200 | 0210 | AM | |
| Examiner | 4a Facility Neme (If not institution, give 1120 MADISON STR | | | | 4b. City, Town, or ANNAPOL 3 | | | of Death C ARUNDEL | | |
| *Funeral Director | 220 21 0203 | 7. Age (In yrs.) | est birthdey) Yrs. | If Under 1 Year Months Days | | (Month, Da | th y. Year) 16, 1975 | 9. Birthplace (State or Fo Country) Maryland | oreign | |
| and * | Usuel Residence of Decedent 10a. Stete 10b. County | 10c. City | , Town or Loc | ation | | | 10d. tnside City Lim | | | |
| vith the Maryl t or 28a-f eho be notified Director | Maryland Anne Arun | del Ar | napolis | | | | 1 □ Yes 2 □ | | | |
| ath with ti 23a or 2 rai Ofro | 10e. Street and Number 413 Hillsmere Driv | | | 10f. Zip Code 21403 | | | 10g. Citizen of Whet Country? USA | | | |
| 72 hours after death with the Maryland natural; or items 23s or 28s-f show deat Emphre mast be coffed at eted by Funeral Director | 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: | | Vas Decedent of I Yes, specify Cub | Hispanic Origin? (Span, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | Specify | e - American Indien, sk, White, etc. | | |
| n 72 hours natural', of called by | 15. Decedent's Edu (Specify only highest grad | | 16a. Deced | ent's Usual Occu | pation during most of wo | rkina | 16b. Kind of Bu | isiness/industry | | |
| C 1 10 100 | Elementary/Secondary (0-12) | College (1-4or 5+) | life. D | | duning most of wo | | Con | acturaction | | |
| | 17. Fether's Neme (First, Middle, Last) | | | Laborer | 18 Mother's Ne | me (First, Middle, | | nstruction | | |
| should be filed within and Mental Hygiene. marked other than matic event, the standard that To Be Comp | Michael D. Hall | Sr | | | | a Davis | Waldon Caman | | | |
| 2 should to marked marked umarked | 19a. Informant's Name/Reletionship (T) | | 19b Mailin | Address (Stree | t and Number or R | | er. City or Town. | Stete. Zio Code) | | |
| d Z | Michael D. Hall Sr. | | | | Dr. Annapo | | | | | |
| 00 - | 20e. Method of Disposition 1 A Buriel 2 Cremetion 3 F | 20b. F | lece of Dispos | ition (Neme of etory or other ple | oce) | Date | 20c. Location - | City or Town, Stete | | |
| it. Per rtant: njury | 4 Donation 5 Other (Specify) | 1)// | - | st Cemeter | | | | s, Maryland | | |
| permit. Peges Department of Important: If it any injury or once. | 21. Signeture of Furniral Service Licens | Lus You | | Neme end Addr | | | | ral Home, Inc. s, Md. 21401 | | |
| Physician /Medical | 23e. Pert1. Enter the disease, or compi shock, or heert tellure. List only of Immediate Cause (Final | 1 | | | | | rrest, | Approximate Interval Betwee Onset and Dec | eth | |
| Examiner | disease or condition resulting in death) | Due to (o | r as a consequ | | head | 1 | | | V. | |
| The law requires that the deeth certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last | Due to (or | r es e consequ r es a consequ | | | | | | | |
| at the deeth cer d by the attendir etached for use Physician/N | Part II. Other significant conditions con | | ulting in the un | derhina ceuse a | iven in Part I | 23h Did | 23b. Did tobacco use contribute to the cause of dea | | | |
| es that the deeth cer igned by the attendir be detached for use by Physician/A | Tarris algunoan conducts con | inibuting to death but not less | and in the on | derlying couse g | | | Yes 2 7 No | 3 Probably 4 Un | | |
| The law requires the law sequires the lass been signed page 2 should be dempleted by | | | | | | | an autopsy ermed? | 24b. Were eutopsy find available prior to completion of caus of death? | | |
| The page | | | | | | 1/2 | Yes 2□No | 1€Yes 2□ No | io | |
| elan: ettic ctor, | 25. Was case referred to medical examiner? | | | | 26. Place of De | ath (Check only o | one) | | | |
| Physician: this certific ral director, | Yes 2□ No | | ER/Outpatien | 3LI DOA | | 1 | | er (Specify) AT SC | ENE | |
| After the funeration: | 27. Manner of Death 1 Netural 5 Pending | 28e. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Inju Wo | ork? Yes 2 ₩No | 28d. Describe | now injury occur | | | |
| tal or Attending Physician: To set of the dath. al Director: After this certificated in by the funeral director, Certification: To Be C | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. Place of Injury - At he building, etc. (Specific | () | | | 28f. Location (City or To | Street and Numb | per or Rural Route Numbe | | |
| To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp | (Check only 2 Medical Exami | SWEEN sicien: To the best of my knowner: On the basis of examine | wiedge, death | occurred at the t | ime, date and place | e, and due to the | Madizan cause(s) and madete and piece, | inner as stated. | 43. | |
| thin 24 mplet | one) | and manner steled. | | | | | | | | |
| Twill Cor | 29b. Signature end title of certifier | The | | | .C.M.E | | JAN. | 23, 2000 | | |
| | 30 Name and address of person who or | | | | , Baltimo | ore, Mar | yland 21 | 201 | | |
| State | 31. Date tiled (Month, Day, Year) | 32. Registrer's Signa | | , , | del | | | | | |

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 3 L

| | | | C | ertificate | of . | Death | | F | leg. No. | | | |
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| | 1. Decedent's Name (First, Middla, L. | est) | | | | | | 2. Data of Dea Month | | Year | 3. Tima of Death | |
| Physician Medical | Herbert Dudley Hi | 11 | | | | | | Jan. | 20, | 2000 | 2:10 PM | |
| Examiner | 4a Facility Nama (If not institution, gi | ve street and number) | | | - 1 | b. City, To | wn, or L | ocation of Death | 4c. County | of Death | | |
| | Ginger Cove | | | | | nnapo | | | Anne | | | |
| Funeral Director | | 1DM ODE | yrs. last birthda 87 Yrs. | y) If Under Months | Days | If Under Hours | 24 Hrs. Min. | 8. Data of Birtl (Month, Day July 22 | Year) , 1912 | 9. Birthpli Count Ala | nce (State or Foreign ry) bama | |
| ehow start | 10a. State 10b. County | | c. City, Town or | | | | | | | 10 | ld. Inside City Limits | |
| Ple N | Maryland Anne Ar | undel A | nnapoli | polis 10f. Zip Code | | | | | 10g. Citizen of What Country? | | | |
| offer death with the Maryland with ferra 23a or 28a-f show name must be notified at Funeral Director | 2104 River Cresce | nt Drive | | 21401 | | | | | United States | | | |
| urs efter | 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? NXYas 2 □ No If Yas Give | MXYas 2□ No If Yas, Give 1□ Yas 2⊠1 | | | ın, Mexican | gin? (Sp i, Puerto | pecify Yes or No- p Rican, etc.) | Blac | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| ygiene. Ner than "naturi It, me Wedcall | 15. Decedant's E (Specify only highest gr | | | edent's Usua va kind of wor | | | t of worl | kina | 16b. Kind of Be | usiness/Ind | ustry | |
| filed within Hygiene. wher then " | Elementary/Secondary (0-12) | College (1-4or 5+) | lifa | . DO NOT us | e retired | 1) | | | 94 | | | |
| Sec at | | 4 | Cap | tain | | | | | U.S. Na | | | |
| permit. Peges 1 end 2 should be filed within Department of Heelth and Mental Hygiene. Important: if New 27 Is marked other than important: if New 27 Is marked other, than Many hijury or other traumatic event, the Means. To Be Compil | 17. Fathar's Name (First, Middla, Las |) | | | | Birdi | | na (First, Middle, uin | Maiden Suman | 10) | | |
| 2 sho and 1 aum | 19a. tnformant's Name/Ratationship | (Type, Print) | 19b. Ma | iling Address | (Street | and Numbe | er or Ru | ral Routa Numbe | r, City or Town, | Stata, Zip | Code) | |
| end 2 n 27 l | Theresa Hill / Wi | fe | 2104 | River | Cre | scent | Dr | ive Ann | apolis. | MD 2 | 1401 | |
| te He | 20a. Method of Disposition | | Ob. Place of Dis | position (Nameratory or of | a of | | | Data | 20c. Location - | City or Tov | vn, State | |
| Peges ment of P mm: If Ne ury or of | 1 ☐ Burlat 2 ☐ Cramation 3 [4 ☐ Donation 5 ☐ Other (Special | JHemoval from Stata (fy) | Valley : | Forge (| Gard | lens | | 1/24/00 | Valley | Forge | Gardens | |
| Departri Importa any inju | 21. Signature of Funaral Sarviou Lice | psee | | 22. Nama and | | | y Jo | ohn M. I | aylor F | unera | 1 Home, Ir | |
| | 23a Part 1. Entar the disease or con | polications that caused the | | | | | | | | napol | | |
| Dhualaian | 23a. Part1. Enter the disages or conshock, or heart failure. List only | ona cause on each line. | | | | , | | or respiratory an | | | Interval Between Onset and Death | |
| Physician /Medical Examiner | Immediata Cause (Final disaasa or condition | CVA | 7 | | | | | | | | luk | |
| | rasulting in death) | | to (or as a cons | | | | | | | | | |
| p # 5 | | , ische | MIC | Cor | dei | Ly | 0/2 | ate | | 1 | 141 | |
| ficate be executed physician and is the bunal-trensit edical Examiner | Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or Injury Cause (Disease (Disea | | | | | | | | | | 100 | |
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| death ce e attendi ed for us | Part II. Other algnificant conditions | 23b. Did tobacco use contribute to the cause of d | | | the cause of death | | | | | | | |
| es that the death igned by the atte be detached for by Physicia | Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | | | ebly 4 🗆 Unknow | |
| aw requires to the second of t | | | | | | | | | | ava | ilable prior to | |
| | | | | | | | | 1 🗆 Y | as 2 No | 1□ | Yes 2□ No | |
| certificate rector, pag | 25. Was casa refarred to medical | | | | | 26. Place | of Dea | th (Check only o | Approximate interval Betwee Onset and Deal Approximate interval B | | | |
| Physical this can all direction To E | examinar? 1 Yes 2 No | Hospital: | 2 ER/Outpat | ient 3 DO | A Oth | er: 4(ZNu | ırsing H | oma 5 🗆 Resid | ence 6 Oth | er (Specify |) | |
| Attending Physician: or death. ector: After this certific by the funeral director, lifeation: To Be (| 27. Mannar of Death 1 Natural 5 Pending 2 Accident Invastigation | 28a. Data of Injury (Month, Day Yea | ar) 28b. Time tnjun | of 2 | Bc. Injur Wor | y at k? Yes 2 | No | 28d. Describe h | ow Injury occur | red | | |
| 2 4 4 E | 3 Suicida 6 Could not to datarmined | | At home, farm, pecify) | street, factory | office | | | | | per or Rural | Route Number, | |
| To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi | 29a, Cartifiar (Check only one) 1 Certifying Pl | nyaicien: To the best of my miner: On the basis of exa and manner stated. | knowledge, demination and/or | ath occurred a investigation, | t tha tir | na, data an pinion, dea | d place, th occui | , and due to the c rred at the time, c | ause(s) and ma late and place, | anner as sto and due to | ated. the cause(s) | |
| omple Me | 29b. Signature and titla of certifiar | 7/ | | 29c | Licens | e number | | | 29d. Date signe | d (Month, L | Day, Year) | |
| F 5 F 0 | > man 4 | Mern M. | 1 | | 03 | 0718 | | | 1-26 | -00 | | |
| | 30. Name and address of person who | completed cause of death | e. 0 | e, Print) | 21 | A | in | geoles | MA | 211 | 101 | |
| State Registrar | 31. Data filed (Month, Day, Year) JAN 2 7 | 32. Registrar's S | Signature | 9. 4 | box | des! | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

| Physician | | | | | | | | 2. Date of D Month | Day | Year O. 15 Or | |
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| Examiner | | lame (If not institution, s odges Lane | give street and number | 7) | | | 4b. City, Town, or Severna | | Anne A | | |
| uneral irector | 213-20 | 0-0847 | Sex 7. A | ge (In yrs. last 74 | Vrs. | If Under 1 Year Months Days | | 8. Date of B. (Month, D. Sept. | 1925 1925 | 9. Birthplace (State or Fo Country) Maryland | |
| I | 10a. State | ence of Decedent 10b. County | | 10c. City, T | own or Loc | ation | | | 0.1 | 10d. Inside City Li | |
| fled a | MD | Anne | Arundel | Sever | rna Pa | ark | | | 10 | | |
| 23a or 28a-f show ust be notified at rai Director | | odges Lane | | | 4.0 | 10f. Zip Code 21146 | 5 | | 10g. Citizen of What Country? USA | | |
| Staminer in Dy Funer | 3 Wide | tatus or Married 2∰ Married owed 4 □ Divorced | 12. Was Deceden Armed Forces 1 Yes 2 S H Yes, Give Year or Dates: | ? (No | 100 | As Decedent of Yes, specify Cut | Hispanic Origin? (Si ban, Mexican, Puerb Specify: | pecify Yes or N o Rican, etc.) | 1755000 | - American Indian, White, etc. White | |
| At the Medical | Elementar 11 | 15. Decedent's (Specify only highest of y/Secondary (0-12) | | | (Giva k | ent's Usual Occu and of work done O NOT use retire r and Op | during most of wor ed) | king | 16b. Kind of Bus Liquor | Control of the Contro | |
| | | Name (First, Middle, La | st) | | ALL CONTRACTOR | | STATE OF THE STATE | ne (First, Middle | , Maiden Sumame | J . | |
| arked out | Cha | rles Helfer | estay | | | | Norma | (Unknow | n) | 10 PM | |
| er trauma | 19a, Informa | nts Name/Relationship Helferstay | Target Control | , | 11-2-27 | | Lane, Set | | CONTRACTOR OF THE PARTY OF THE | State, Zip Code) 21146 | |
| int: If Iham ary or other | 20e. Method of Disposition 20b. Place of Disposition (Name of connection, computery, com | | | | | | | | City or Town, State | | |
| i i | resulting in o | buse (Final codition seath) | . Can | Due to (or as | 6 consequ | ES o | phagus | 3 | | 3 M O-W | |
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Philip Gibbon Hammer 21, 2000 January 10:50 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium Health & Rehabilitation Ctr. Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 258-42-8751 85 Sept. 18,1914 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 Yes 2XNo Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 521 Holly Road 21037 USA "natural", or flams 23a 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after de if Hygiene. other then "neturel", or flem Black, Whita, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit. Department of Health and Mental Hygiens irreportants if Nam 27 is marked other than any fillury or other traumatic event, that a once. Economist Economics 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be John Leverling Hammer, Sr. Gibbon Emma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Jane A. Hammer/ Wife 521 Holly Road Edgewater, Maryland 21037 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removel from State 1-24-00 Philadelphia, PA Ivy Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility George P. Kalas Funeral Home 21 Signature of Funeral Sendon Libr 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician tmmediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner OSTAT physician and the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last MICRO Box 68760 Physician/Medical Due to (or as a consequence of) 280 23b. Did tobacco use contribute to the cause of death? Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes certificata 1 ☐ Yes 🏖 No 1 ☐ Yes 2 ☐ No. Division of Vital or Attending Physician: director. 25. Wes case referred to medical axaminer?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 412 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of trijury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours efter death. To the Funerel Director: Aft completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours e To the Funerel D According Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The fical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier edical (Check only 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) January 21, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Watkins 21401 BEST 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

Registrar **DHMH 16 Rev 6/95**

State

JAN 2 7 2000

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 21 2000 JAN. 4:30 pm ETHEL L. HYNSON /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ANNE ARUNDEL 7994 H. SILENT WIND COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 25 1940 MARYLAND 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2ØF Hours 219-36-8956 59 Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 X Yes 2 No Directo GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with USA Funeral 7994 н. SILENT WIND COURT 21061 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XI No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 No Specify: Ď 3 ☐ Widowed ♣☐Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglana. Important: if hem 27 le marked other than "natteny or other traumatic avent, the Medical PAGE. 15. Decedent's Education (Specify only highest grade completed) CROWNSVILLE STATE Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL 12th LPN (NURSE) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 ELLEN SMITH CHARLES JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 19a. Informant's Name/Relationship (Type, Print) 8037 MANSION HOUSE CROSSING PASADENA, MD. MICHELLE GREEN (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 12 Burial 2 ☐ Cremation 3 ☐ Removal from State HILL CREST CEMETERY 1/28/2000 ANNAPOLIS, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Lavry J. Reese 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician BreasT Immediate Cause (Final disease or condition resulting in death) /Medical Concer an etastotre years Examiner Examiner physician and the burlet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) 100 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were sutopsy findings available prior to completion of cause of death? been alg 24a. Was an autopsy performed? Completed certificata has 1 Yas 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifica completaly illied in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 700 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) as 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aguahnot Rd Glea Burnierozio61 Gorba 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JAN 28** Registrar

JAN 28 2000 James of section

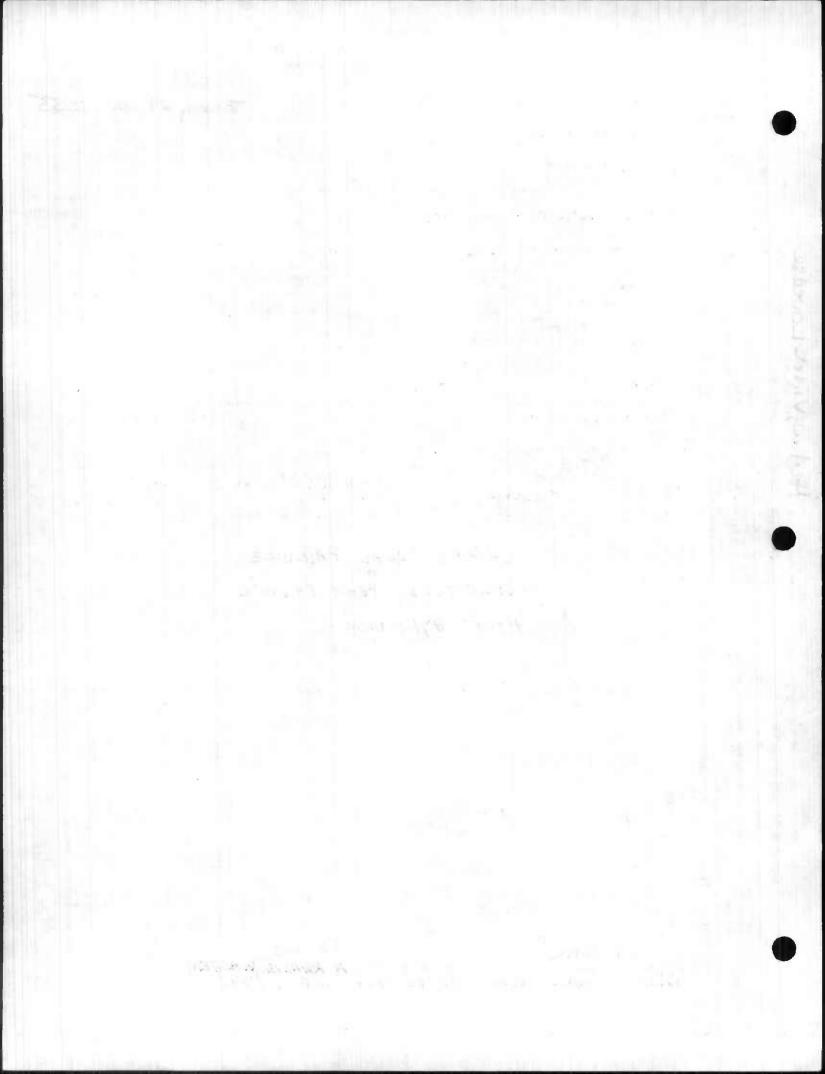
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Harlay, Violet Lovease

To the Hospital or Attending Physician: The law requires that the death certificate be associted Division of Vital Records, P.O. Box 68760,

| | | | d / Depa <i>Cei</i> | rtificate of | Death | F | leg. No. | 00130 | | | |
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| | 4a Facility Name (If not institution, give street | | | 4 | lb. City, Town, or Li | | | | | | |
| er | | * | 1 | | Hagers | town | | | | | |
| | 5. Sociel Security Number 6. Sex | 7. Age (In yrs. li | | If Under 1 Year | If Under 24 Hrs. | | | 9. Birthplace (State or Fo | | | |
| | 200 24 2770 | % 90 | Yrs. | Months Days | riours Mwi. | January | 3, 191 | O Virginia | | | |
| | | 10c City | . Town or to | cation | | | | 10d. Inside City L | | | |
| ō | | | | | | | | 1 [X] Yes 2[| | | |
| rect | 10e. Street and Number | | 3 | 10f. Zip Code | | 1 | l0g. Citizen of V | What Country? | | | |
| | 33 South Locust : | Street | | 21740 | | | U.S | . A . | | | |
| ner | 11. Merital Sletus 12. W | as Decedent Ever in U. | S. 13. \ | Wes Decedent of H | ispanic Origin? (Sp | ecity Yes or No- | | | | | |
| | 1 Nevar Married 2 Married 1 | ☐ Yes 2 No | | | | racan, etc.) | | 1.11. | | | |
| | 3 □ Widowed 4 Ø Divorced Ye | eer or Delas: | | | | | | | | | |
| lete | | pleted) | 16a. Deced (Give | ient's Usual Occup kind of work done o DO NOT use retired | ation during most of work f) | ing | 16b. Kind of Bu | ismess/Industry | | | |
| ошо | Elementery/Secondery (0-12) Co | oilege (1-4or 5+) | | | | | Own F | Home | | | |
| | 17. Falher's Neme (First, Middle, Last) | | | | | e (First, Middle, | | | | | |
| 0 8 | Frank | P | umphr | еy | Flora | Э | | Busby | | | |
| | | | 19b. Meilir | ng Address (Street | | | | | | | |
| | Mary R. Bloyer | | | | st Stree | t, Hager | stown, | ld. 21740 | | | |
| | 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremelion 3 ☐ Remov. | 0 06 | emetery, cren | netory or other pled | (8) | Date | | | | | |
| | 4 Donelion 5 Other (Specify) | Cec | | | 1 | | | | | | |
| | A. hall Bra | Accounty Accounty | Inc. own, Md. 217 | | | | | | | | |
| edicai | Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediata cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in dealth) Lest Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | |
| 48 Facility Name (if not institution, give street and number) 49 Shington County Hospital 40 City, Town, or Location 40 Hagerstowin 41 Hagerstowin 41 Horizot Alexa 40 Hours Merit 40 County 40 City, Town or Location 40 Location 41 Hagerstowin 42 Location 43 South Locust Street 40 County 41 Horizot Alexa 41 Location 42 Location 44 Location 45 Location 46 Location 46 Location 47 Location 48 Location 49 | 23b. Did tobacco use contribute to the cause of | | | | | | | | | | |
| ysician/ | Part II. Other significant conditions contributi | ing to death but not resu | ilting in the u | nderlying cause giv | en in Pert I. | 23b. Did to | | | | | |
| | Part II. Other significant conditions contributi | ing to death but not resu | ilting in the u | nderlying cause giv | en in Pert I. | | | | | | |
| by | Part II. Other significant conditions contribution | ing to death but not resu | iting in the u | nderlying cause giv | en in Pert I. | 1 🗆 \ | res 2⊠No | | | | |
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| e Completed by | 25. Was case referred to medical | ing to death but not resu | ilting in the u | nderlying cause giv | | 24a. Was a perfor | en autopsy med? | 3 Probably 4 Un 24b. Were autopsy lind available prior to completion of cause of death? | | | |
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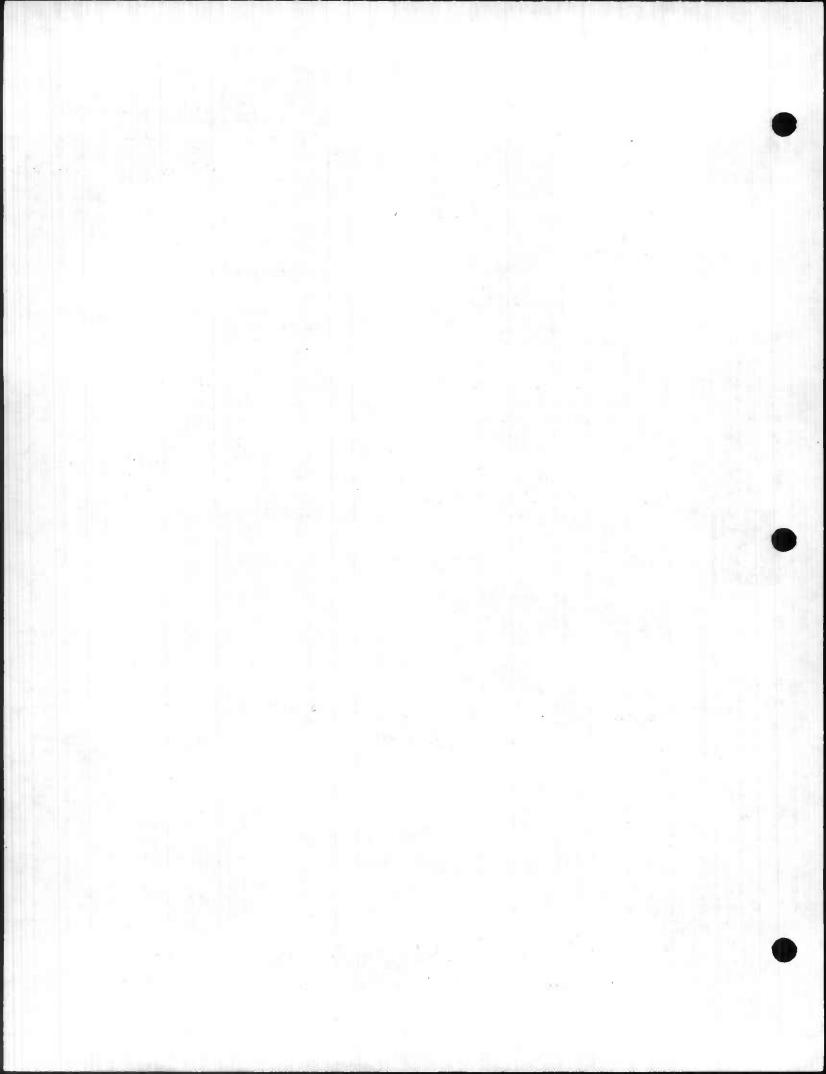
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State of Maryland / Department of Health and Mental Hygiene 00 05 139

| | | | Cer | tificate of | Death | В | ng. No. | 05139 | | |
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| Dhyelelen | 1. Decedent's Neme (First, Middle, Last) | | | | | 2. Date of Deat Month | h Day | 3. Time of Death | | |
| Physician /Medical | | ylis HEIRONIN | AUS | | | JANVA | vy 29 | 00 1715 | | |
| Examiner | 4a Facility Name (If not institution, give a Washington County | | | 1 | tb. City, Town, o Hagerst | r Location of Death | '4c. County | of Death nington | | |
| Funeral | 5. Social Security Number 6. Sec | 7. Age (In yrs. Is | | If Under 1 Year Months Days | If Under 24 H | rs. 8. Date of Birth | | 9. Birthplace (State or Foreig Country) Washington, D | | |
| Director | 214 07 7313 | M 2□F 8 | 8 Yrs. | months Days | 710010 | May 10, | 1911 | Washington, D | | |
| Pu k | Usuel Residence of Decedent 10a. Stete 10b. County | 10c. City | , Town or Loc | cation | | | 10d. Inside City Limi | | | |
| e Maryl Be-f aho the d | Maryland Washingt | | erstown | | | | 1 ☐ Yes 28 | | | |
| ith with the Ma 23e or 28e-fa ust be noutled | 10e. Street and Number 15325 National Pik | e | | 10f. Zip Code 217 | 40 | 1 | 10g. Citizen of What Country U.S.A. | | | |
| 172 hours effer death with the Maryland natural; or flems 23a or 28a-f ahow ideal Examiner must be notified at eted by Funeral Director | 11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: | | Ves Decedent of H Yes, specify Cuba | | (Specify Yes or No- erto Rican, etc.) | Blac | - American Indian, k, White, etc. - White | | |
| led within 72 ho lygiene. Nor than "natura it, me Medical Completed | 15. Decedent's Educ (Specify only highest grade | | 16a. Deced | ent's Usual Occup | ation during most of w | rorkina | 16b. Kind of Bu | siness/Industry | | |
| within in the fact of the fact | Elamentary/Secondery (0-12) | College (1-4or 5+) | | kind of work done | | | o i was | * o f + | | |
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| 2 should be filed with and Mental Hygiere. a marked other than aumatic event, the IV | 17. Father's Name (First, Middle, Last) Fervin 0 | . Heironimus | | | 18. Mother's N | eme <i>(First, Middle, I</i> Lillie | | • | | |
| 1 and 2 sho Heelth and N em 27 la ma ther trauma | 19e. Informant's Neme/Ralationship (Ty Mrs. Linda Ward - | | 19b. Mailin | g Address (Street Nationa | and Number or a | Rural Route Number Clear Spr | City or Town, | State, Zip Code) aryland 21722 | | |
| 500 | 20e. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □ R 4 □ Donetion 5 □ Other (Specify) | | | sition (Nama of netory or other place 1 Cemete | | Feb. 1. | | City or Town, State OWn, Maryland | | |
| permit. Peg Department Important: If any Injury o 2000. | 21. Signeture of Funeral-Service License | Minus. | / / | Name end Addre | | Minnich I | Tuneral | | | |
| | 23a Part 1 Enter the disease or compli | cations that caused the death | | | | | | Approximata | | |
| Dhysisian | 23a. Part1. Enter the disease, or compli- shock, or heart feiture. List only or | e ceuse on eech lina. | . Do not onte | a the mode of dyn | ig, such as card | ac or respiratory or | 551, | Interval Between Onset and Death | | |
| Physician /Medical | Immediate Ceuse (Finel | 1) | 1 | 1 | | | | daste | | |
| Examiner | disease or condition resulting in deeth) | de /1 | Java | 7/011 | | | | 10175 | | |
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| axacuted in and fial-transit Examiner | b. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. | | | | | | | | | |
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| of the death cer d by the attendir etached for use Physician/A | | | | | | | | | | |
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| | 25. Was casa ratarred to medical axaminer? | | | | 26. Place of D | eath (Check only on | (e) | | | |
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| th.: After the funeral | 27. Manner of Death ↑ Natural 5 ☐ Pending 2 Accidant investigation | 28a. Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. tnjur Wor | yat k? Yes 2 ☐ No | 28d. Describe ho | ow injury occurr | ed | | |
| is of Attending Programmers and Director: After the did in by the funeraction: | 3 Suicide 6 Could not be datermined | 28e. Place of Injury - At hor building, etc. (Specify) | ne, ferm, stre | eet, fectory, office | | 28f. Location (St City or Town | | er or Rural Route Number, | | |
| To the Hospital or Attending I within 2 the Johns after death. To the Funeral Director: After completely filled in by the funer Medical Certification: | 29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one) | lician: To the best of my knowner: On the basis of axamination end menner steted. | rledge, death on and/or inv | occurred at the tin estigation, in my o | na, data and pla pinion, death oc | ce, and due to tha courred at the time, d | ause(s) and ma ata and place, a | nner as stated. and due to the cause(s) | | |
| Within Somple | 29b. Signeture end title of cert | 114 | ^ | 29c. Licens | e number | 2 | 9d. Date signed | i (Month, Day, Year) | | |
| ->-0 | 1011 | 11 a. la - 11. | ,() | n. | 01/0/0 | | are. | 30 00 | | |
| | 30. Neme and address of person who co | mpleted cause of death (Item | 23a) (Type, F | Print) | 11/266 | | Jun | 10 | | |
| | H. N. We | eks 58 | O Nor | Thern 1 | Av 1 | tagento | 154 / | ML | | |
| State Registrar | 31. Date filed (Month, Dey, Year) LAN 3 1 20 | 32. Registrar's Signatu | G. | Span | h | / | | | | |



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\mathbb{U} \, \mathbb{U}$ Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 2000 JANUARY 4:40 PM MAY HUFFER OTILIA 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOMEWOOD RETIREMENT CENTER WILLIAMSPORT WASHINGTON 8. Dete of Birth (Month, Dey, Year) NOV. 13, 1 5. Sociel Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Deys Months Hours Country) MARYLAND Yrs 213-74-4468 100 Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 1 Yas 2 No MARYLAND WASHINGTON WILLIAMSPORT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16505 VIRGINIA AVENUE 21795 U.S.A. Rece - Amaricen Indian, Biack, White, atc. 12. Wes Decedenl Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Yes 2 No If Yas, Giva Yaar or Detes: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) OWN HOME HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Surname) THOMAS COWAN PEARCE AGNES C. SHAW 19a. informant's Neme/Raletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) EULA H. SWAIN/DAUGHTER 16824 HAMPTON ROAD, WILLIAMSPORT, MARYLAND 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2/2/00 BOONSBORO, MARYLAND BOONSBORO CEMETERY 21. Signature of Funerei Service Licensee 22. Nema end Addrass of Facility 7606 Old National Pike DAST FUNERALHOME Steven Danfelt Jr. Boonsboro, Maryland 21713 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervai Between immedleta Ceuse (Finel disease or condition resulting in deeth) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceues givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed?

Physician /Medical Examiner

signed by the attending physician and d be detached for use as the burial-transit

peed

funeral

ospital or Attending Pr. hours after death. unerel Director: After th

To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the

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Certification:

Medical

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

10a. Stete

Director

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Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hybinea. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examine must be notified.

2 should be filled within 72 hours after death vand Montal Hygiene.
Is marked other than "natural", or items 23

Baitimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Physician/Medical þ Completed

OANGREA

5 Pending investigation

Could not be datarmined

25. Wes case referred to medical examiner?

31. Data filed (Month, Dey, Year) FEB 0 1

1 Yes 2 No

27. Menger of Deeth

1 Netural

2 Accident

3 Suicide

2 No

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28b. Time of 28c. Injury at Work? 1 Yas 2 🗆 No

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledga, daath occurred et the time, dete end piece, and due to tha cause(s) and manner as stated.
2 Madicat Examiner: On the basis of exemination end/or investigation, in my opinion, daeth occurred at tha time, data end piace, and dua to tha cause(s) end mennar statad.

29e. Certifiar (Check only one) 29c. License number 29d. Date/signed (Month, Day, Year)

29b. Signature and little of 5000 laterior

1 Inpatient 2 ER/Outpatient 3 DOA

implated cause of death (Itam 23e) (Type, Print)

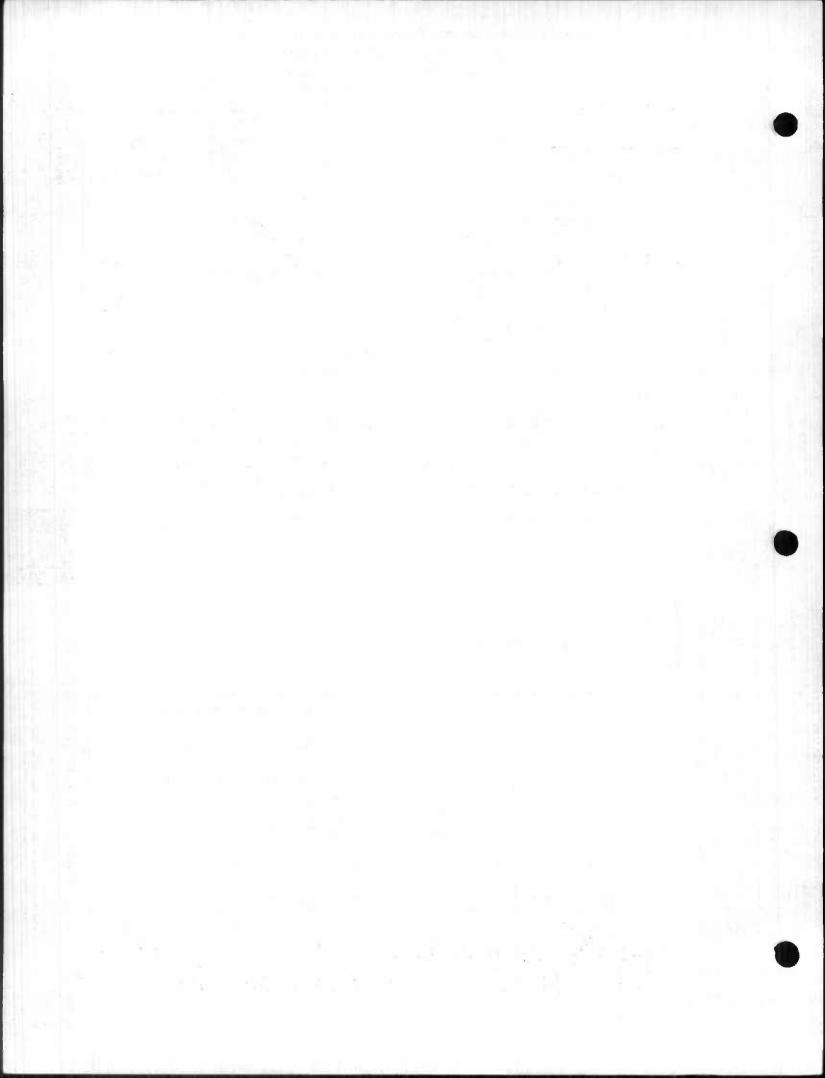
2000

Hospitel:

28e. Dete of Injury (Month, Dey Year)

32. Registrer's Signeture

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month HARRISON WAVA 7:20 A.M. JANURY 26 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 98 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1□M 2以F Months West Virginia 220-92-8642 101 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Frederick Thurmont 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14835 Mud College Rd. 21788 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Merital Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify: 3.10 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working title. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Hamo 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Corbin Dorabelle Fisher 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14835 Mud College Rd. Thurmont, Md. 21788 Jacqueline Danforth (Daughter) Jan. 27, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Smithsburg Crematory 2000 Donation 5 Other (Specify) Smithsburg, Md. 22. Name and Address of Facility Signature of Funeral Service License 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Congestive Heart Failure Immediate Cause (Finat disease or condition resulting in death) Two Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as e consequence of) Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No

Physician /Medical Examine

that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

this

After

or Attending

Physician

/Medical

Examiner

10a. State

Md.

Funeral

Director

28a-f show

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Norms 23s

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or list my Injury or other traumatic.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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the Maryland

attending physician and for use as the burlat-transit

Examiner Physician/Medical þ Completed Be Certification: To To the Hospital or Attending within 24 hours after death.

To the Funeret Director: Afte completely filled in by the fun edicai

27. Manner of Death

25. Was case referred to medical examiner? 1 Yes 2 No

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year) 28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how Injury occurred

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year) 28 2000

Name and address of person who completed cause of death (Item 23a) (Type, Print) 15201 Shady Grove Rd #202, Rochville MU

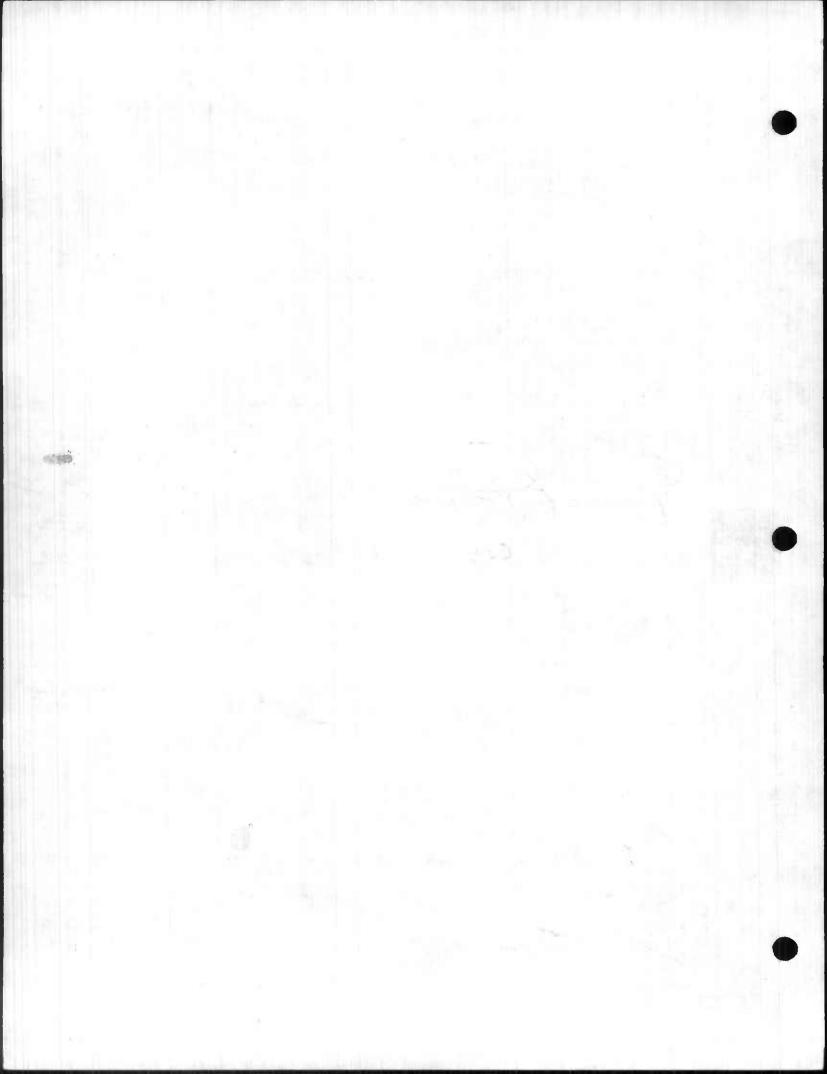
Hospitat:

STEVEN CONTRE MD 2000

32. Registrar's Signature

State

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death 26, 2000 Month **Physician** January 7:10am Joseph James Humble /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BETHESDA Montgomery Co. SUBURBAN HOSPITAL 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Days 1□M 2□F Months Hours Yrs. 579-09-9231 88 Carolina Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow with the Maryla the Medical Examiner must be notified at X Yes 2 No Director D.C. N/A Washington Nerns 23s or 28s-f 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral Road, N.W. 20001 U.S.A. 534 Columbia 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Rece · American Indian, Bleck, White, etc. be filed within 72 hours after ☐ Yes 21 No Yes, Give 1 Never Married 2 Merried b 21215-0020 Specify: Black 1 ☐ Yes 2 CNio Specify: Completed by 3 ₩idowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry il Hygiena. other than Elementery/Secondary (0-12) College (1-4or 5+) 3rd Self-employed Clergy Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be h and Mental h Emma Grooves Pages 1 and 2 should John Humble 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any Injury or other trax 534 Columbia Road, N.W.; WDC Michael Humble - Son 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1XDaurial 2 ☐ Cremation 3 ☐ Removel from State Forest Hills Cemetery 2/2/00 Clinton, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licen 22. Name end Address of Facility
Robert O. Freeman Funeral Servvice, Inc. TOMMAN. example) WDC 20002 1353 H Street, N.E. 23a. Pert1. Enter the disease, or comprications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediata Cause (Finel disease or condition resulting in death) 1 month Aspiration Pneumonia Examiner Due to (or as e consequence of) Examiner attending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? peed completion of cause of death? 1 ☐ Yes X No 1 ☐ Yes 2 ☐ No I or Attending Physicien: after death. Director: After this certific director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗷 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending Investigation 1 Netural 1 TYes 2 No 2 Accident the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) pletely filled in by 4 T Homicide To the Hospital of willing 24 hours a To the Funeral D 29a. Certifier 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) at D0053615 27 Januaay 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Aruna S Nouhan i2 | Congr 121 Congressional Lane, Rockville 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 1 ZUUU Registrar

DHMH 16 Rev 6/95

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 0 05 143

| Physician /Medical Examiner uneral irector | 4a Facility Nan | Name (First, Middle, L ne (It not institution, g Ince George | Sally May | Harms | | | | 2. Date of Dear Month | | 3. Time of Dea | | | |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------|--------------------------|-------------------------------------|-----------------------|---------------------------------------------------------|----------------------------------------------------|-----------------|---------------------------------------------------------------------|-----------|--|--|
| /Medical Examiner uneral irector | Pri 5. Social Secur | | | Harms | | | | 141011111 | Uay_ | 1 001 | | | |
| uneral irector | Pri 5. Social Secur | | ive street and number | | | | | January | | 2000 08:46 | A.M. | | |
| irector | 5. Social Secur | nce George | | | | | 4b. City, Town, or L | ocation of Death | 4c. County | y of Death | | | |
| irector | | | do | | | | Cheve | | | ce George's | | | |
| how Lat | | 6451 | | Age (In yrs. last bir | Yrs. If Under Months | 1 Yeer Days | If Under 24 Hrs. Hours Min. | | | | | | |
| E 5 | Usual Residend | to of Decedent | | 10c. City, Tow | or Location | | | | | 10d. Inside City L | lmite | | |
| * 32 - 5 | 12 - 31 | | Comment | | TOT ECOMION | | | | | 1 Yas 2 | | | |
| notifie | Marylan | | George's | Largo | 101 71 | 0.4 | | | 0.00 | - | n. | | |
| count be notified at neral Director | 10e. Street and | Crack Will | low Court | | 10f. Zip | 207 | 74 | | USA | What Country? | | | |
| Fune | | Married Married | 12. Was Deceder Armed Force 1/1/1/9s 2[If Yes, Give | s? 1961- | 13. Was Deced | | dispanic Origin? (Sp an, Mexican, Puerto Specify: | pecify Yes or No- Pican, etc.) | Bla | ce - American Indian, ck, White, etc. | | | |
| dical Ex | 3 Wildowed 4 Divorced Year or Dates: 1.904 | | | | | Λ | | | Specin | White | | | |
| dica | 15. Decedent's Education (Specify only highest grade completed) | | | | Decedent's Usua (Give kind of wo | rk done | pation during most of work d) | king | 16b. Kind of B | usiness/Industry | | | |
| ypions. we then "natural, t, the Medical. Completed | Elementary/Secondary (0-12) College (1-4or 5+) | | | | Registe | | | A | Nurs | ina | | | |
| | | ma (Cina Adiddle An | | | Regisee | .I Cu | | Aother's Neme (First, Middle, Ma | | Nursing Maides Summer | | | |
| merked of merked of merked of | Carl Gustav Arnold Wickman Clara | | | | | | | | | ne) | | | |
| | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura | | | | | | | ral Route Number | r, City or Town | , State, Zip Code) | | | |
| ant: If it ury or o | John H | I. Harms/Hu | isband | | Same as | it | em 10 | and rights realized, only or rown, state, Elp code | | | | | |
| | | Disposition 2XXCremation 3 on 5 Other (Spec | | Date 4/2000 A | | - City or Town, State | | | | | | | |
| | | Funeral Service Lio | | | | | 1 | j | | | | | |
| | 1 | 1011 | 11 | | | | kalas Fun | | | | | | |
| | 230 Part 80 | ter the disease or on | nolications that caus | ed the death Do | of enter the mod | on . | Hill Rd. | Or respiratory err | L, Md. | 20745 Approximate | | | |
| | strock, or | ter the disease or on heart failure. List onl | y one cause on each | line. | | 1 | 1 | | | Interval Betwee Onset and Dea | en eth | | |
| sician edical | Immediate Cer | ıse (Finel | | A/ | 1. | 1 | 0/0 | 1 | 0 | 500 | | | |
| iner | disease or con resulting in dec | dition | 8. | V | mi | 1 | INIC | | 110 | ries | | | |
| - n | | , | | Due to (or as a | consequence of): | • | V | | J | | | | |
| Examiner | | | b | | | | | | | | | | |
| s the bunal-transit edical Examir | Sequentially lis | t conditions, | | Due to (or as e | consequence of): | | | | | | | | |
| | Ceuse (Diseas | Inderlying e or injury | C | | | | | | | i | | | |
| 20 | Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): | | | | | | | | | | | | |
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| for us | | | | | | | | | | | | | |
| etached for us Physician/ | Part II. Other al | gnificant conditions | contributing to death | but not resulting in | the underlying o | ause gi | ven in Part I. | 23b. Did tobacco use contribute to the cau | | | leath? | | |
| | | | | | | | | 1 🗆 Y | 08 2 No | 3 Probably 4 Uni | known | | |
| 2 2 | | | | | | | | | | Data Mara auto-ou find | | | |
| Completed | | | | | | | | 24a. Was a perfor | | 24b. Were autopsy findi available prior to completion of caus | | | |
| Сотрі | | | | | | | | | | of death | | | |
| 5 | | | | | | | | 1 1 Y | es 2 No | 1 d Yes 2 □ No | | | |
| Be | 25. Was case i | eferred to medical | | | | | 26. Place of Dea | th (Check only or | ne) | | | | |
| To Be | examiner? | 2□ No | Hospital: 1 ☐ Inpa | atient 2XXER/Ou | tpatient 3 DC | DA Ot | her: 4 Nursing H | ome 5 Resid | ence 6 DOti | her (Specify) | | | |
| | 27. Manner of 8 | | 28a. Date of tr | Nery Year) 28b. | Time of 2 | 8c. Inju Wo | ry at | 28d. Describe h | ow Injury occu | med office ice | 100 le | | |
| at of | 1 Natural | | | 100 0 | 740 | | Yes 2 No | Callide | 70 2 | th another velo | we. | | |
| y the | 3 ☐ Suicide | 6 Could not | Zoel Lisce of | njury - At home, fa | rm, street, factor | y, office | | 28f. Location (S | treet and Num | ber or Rural Route Number | 1 | | |
| | 4 Homic | ide | building, | etc. (Specify) | F 202 | + | House | Sity of Tow | n, state) | · hoseer Ca | W | | |
| Sin b | | 1□ Certifying P | hyalcian: To the bes | st of my knowledge | death occurred | at the ti | me date and place | and due to the o | ause(s) and m | ranner as sheed | 1.00 | | |
| filled in by the funeral Certification: | 29a Certifier | | | of examination an | | | | | | and due to the cause(s) | . 11 | | |
| | 29a. Certifier (Check onl) | ZIAI MACICIII EXI | and manner | orated. | 200 | . Licen | se number | 2 | Od Date slone | | | | |
| Medical Certif | (Check only one) | -14 | | | | | | | | ed (Month, Dav. Year) | | | |
| edicai | (Check only one) | and title of Cartifier | -0- | 41 | N 25 | | | | .so. Date signi | ed (Month, Day, Year) | | | |
| edical | (Check only one) | -14 | taner | M. | D | 0. | C.M.E. | | | ary 30, 2000 | | | |
| edicai | (Check only one) 29b. Signature | -14 | taner | death (Item 23a) | (Type, Print) | | | | Janua | ary 30, 2000 | | | |
| edical | (Check only one) 29b. Signature 30. Name and | and title Partifier | taner | f death (Item 23a) Tanch | (Type, Print) | | | | Janua | | | | |

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** GUBOYS 2211 TANUMAY u HARDIMIN 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SILVER SPUNG HOLY GROSS HOSPITTOL MONTGOMENY H Under 24 Hrs. 8. Data of Birth
Hours Min. Sept. 14, 1934

9. Birthplace (State or roregy)
Country)
North Carolina 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖫 F Months 65 **Director** 244-48-4267 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Prince Georges Maryland Directo Forestville 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 6307 Hill Mar Drive #3 20747 United States of America Norne 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Waa Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. d other than "natural", or items event, the Medical Examiner II filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1) Yes 2 No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Presser Dry Cleaning/Private 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 ahould be fit ment of Health and Mental H tart: If them 27 is mericad off jury or other transmetic even Be Ceasar Cooper Mollie Kearney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Ralationship (Type, Print) Nancy A. Henderson/Daughter 15104 Jennings Lane Bowie MD. 20721 20b. Place of Disposition (Name of 20a. Method of Disposition 20c, Location - City or Town, State Harmony Memorial Park 2/1/20 1 Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any Injury or 4 ☐ Denation 5 ☐ Other (Specify) Landover, Maryland 00 21. Signature of Funeral Service Moensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy ST NW WDC 20011 Pm11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset and Deeth **Physician** YULMONARY EMPOUSA immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? CHOOMIC OBSTANGING PRIMARY DISTANCE 1 Yes 2 No 3 Probably 4 Unknown Records. þ 88 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 2 2 10 Division of Vital or Attending Physician: 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 18 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Yes 2 No death. investigation 2 Accidant after death 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 ☐ Homicide filled in 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sigh attre end title of certifier (OME 015236 townsor 26, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHU I. MANGOUS (MO - INTS LOCKVIUS PIKE, ROQUIUS, MO 20852 31. Date filed (Month, Day Year)
JAN 3 1 2000 Registrer's Signeture State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene-

| Physic | an | 1. Decedent's Neme (First, Mid | die, Last) | | | rtificate of | | 2. Dete of De Month | - | 3. Time of Death | |
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| /Medi | | Columbus Hall | | | | | | Januar | - | | |
| Exami | | 4a. Facility Name (If not institute Mariner Health | | | | | 46. City, Town, o Kensingt | r Location of Dee | | of Deeth gomery | |
| Funeral Director | | 5. Social Security Number 578–18–3277 | 6. Sex | _ | s. last birthdey) | If Under 1 Year Months Deys | | s. 8. Dete of Bi | | 9. Birthpiece (State or Fore Country) Washington, I | |
| anyland show dat | J. | Usuel Residence of Decedent 10a. Stete 10b. Coun | ty | 10c. C | City, Town or Lo | ocation | | | | 10d. Inside City Limit | |
| with the Marylar a or 28e-f show be notified at | Director | 10e. Street and Number | | | Washin | gton D.C | • | | 10a Chizan of I | tizen of Whet Country? | |
| € 23 € | rai Dir | 2306 14th ST N | | | | 20018 | | | United States of Ame | | |
| ours after dea rail, or items Examiner m | by Funeral | 11. Mantel Stetus 1 Never Merried XX Ma 3 Widowed 4 Divorce | If Yes Gi | 2 □ No ve | | Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2🗓 No | | (Specify Yes or Norto Rican, atc.) | | e - American Indian, ck, Whita, etc. ,. Black | |
| illed within 72 h Hygiene. ther than *natu ert, the Medical | Completed | 15. Decede (Specify only high Elementery/Secondery (0-12) 12th grade | ent's Education lest grade completed) College (1 | 1-4or 5+) | 16e. Dece (Give life. Clerk | dent's Usuel Occup kind of work done DO NOT use retire | petion during most of w d) | rorking | 16b. Kind of B | nent | |
| 8 4 5 8 | To Be Co | 17. Fether's Neme (First, Middle Lum Hall | e, Last) | | ozer. | | 18. Mother's Neme (First, Middle, Melden Surname) Mary Ellen Ashton | | | | |
| | | 19e. Informent's Neme/Reletion Denise Hall/Wi | | | | | (Street and Number or Rural Route Number, City or Town, Stete, 2 ST NE Washington D.C. 20018 | | | | |
| emil. Pages 1 ar Separtment of Hea reportant: If them 2 my injury or other stice. | | 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion | 2 Demovel from | 20b. | Place of Dispo cometery, cre | osition (Neme of metory or other ple | | Dete | | City or Town, Stete | |
| arth. Pag artment ortant: I injury o | | 4 Donetion 5 Other | (Specify) | C | • | ike Crema | , | 2/1/2000 | | | |
| permit Depar Impor any ir | 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility Johnson & Jenkins 716 Kennedy ST NW WDC 20011 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart feilure. List only one cause on each line. | | | | | | | | | | |
| Physician /Medical Examiner bhysician and physician and streep physician and physicia | Examiner | tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | P. D. | New | (or as a consector as a consector) | quenca of): | | | | Intervel Between Onset end Deeth | |
| requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burtal-trensit | an/Medicai | Ceuse (Disease or Injury that initieted events resulting in deeth) Last | d | Due to (| (or es e consec | quence of): | | | | | |
| the att | ysich | Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given | | | | | | 23b. Did | l tobacco use co | ontributa to the cause of death? | |
| that the dended by the sidetached | y Ph | | | | | | | 1 | ☐ Yea 200 No 3 ☐ Probably 4 ☐ L | | |
| > 40 | Completed by Physician/M | Altzheime | rs Diza | erse | | | | 24a. Wes | s an autopsy lormed? | 24b. Were autopsy findings available prior to completion of cause of death? | |
| victor: The lev certificate has rector, page 2 | | | | | | | | 10 | Yes 2 No | 1 ☐ Yes 2 ☐ No | |
| | o Be | 25. Wes case referred to medic examiner? 1 Yes 2 No | Hoenital: | | 7500 | Ott | 300 | eeth (Check only | | | |
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| To the Hospital or Attendia within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu | Certification: | 3 Sulcide 6 Could 4 Homicide deter | mined 289. Pleca | of Injury - At I | home, ferm, str | reet, fectory, office | | | (Street and Numb own, Stete) | per or Rural Route Number, | |
| the Hospi in 24 hou the Funer ipletely fill | Medicai | 29e. Certifier (Check only one) 12 Certify 2 Medica | ing Phyatcian: To the it Examiner: On the ba and men | best of my kn asis of examin ner steted. | owledge, deet etion end/or in | n occurred et the ti vestigetion, in my o | me, dete and ple opinion, death oc | ca, end due to the curred at the time | e cause(s) and ma , dete and piece, | anner es stated. and due to the cause(a) | |
| To To | 2 | 29b. Signeture and title of certif | alle | ~ m) | | 29c. Licens | | 95 | | d (Month, Day, Year) - 2000 | |
| (5) | | 30. Name and address of perso | Allan | / 6 | 652: | Print) 5 Be | lere si | L ld | - Hype | -2000 Haville, Md | |
| | | 31. Unite themananth Day Yes | 72 20 20 | egistrer's Sign | eture | | | | | - | |
| Sta Registr | te ar | 31. Date flied Worth, Dey, Yea | 00 3 | | | frag | | | | | |

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death January 26, 2000 1230 PM Joseph Edward Hammond 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death #18 2nd Street Anne Arundel Lothian 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpiece (Stete or Foreign Country) 1**2** M 2□ F Months Days Hours Min Yrs. 19,1930 577-40-3950 69 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 XNo Lothian Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #18 2nd Street 20711 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whila, atc. 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Office Elementary/Secondary (0-12) Colfege (1-4or 5+) 12th Printer Government Printing 18. Mother's Name (First, Middle, Meiden Sumema) 17. Father's Name (First, Middle, Last) Joseph A. Hammond Kathleen Isenberg 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 231 Nightingale Ave. Stevens City VA 22655 Steve Hammond (Son) Feb. 1, Date 2000 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Doylesburg PA St. Mary's Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Lice 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disaase or condition resulting in death) Arteriosclerotic Heart Disease Unknown Due to (or as e consequence of). Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lasl Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4♥ Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of causa of death? 1 ☐ Yes 2 No 1 Yes 2 XNo 25. Was cese referred to medical examiner?
1 ✓ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10e. State

Directo

Funeral

P

Completed

Funeral

Director

7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified as

pemit. Pages 1 end 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Medical Example meant once.

Baltimore, Maryland 21215-0020

with the Meryland

Examiner 98 980 page 2 s

physician and the burial-transit the death certificate be executed certificate hes funeral death.

P.O. Box 68760,

Physician/Medical by Completed Be 10 Certification:

Division of Vital Records, 24 hours after deat Funeral Director: Hospital edical To the Hosp within 24 hos To the Fune completely fi

5 Pending

investigation

6 Could not be

27. Manner of Death

14 Natural

2 Accident

3 ☐ Sulcide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifie

Deputy

28a. Dete of Injury (Month, Dey Year)

29c. Licensa number

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) and manner es stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29d. Dala signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name and address of person who contracted cause of deeth (item 23a) (Type, Print) 695 America 21035 40 ones

32. Registrer's Signature

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

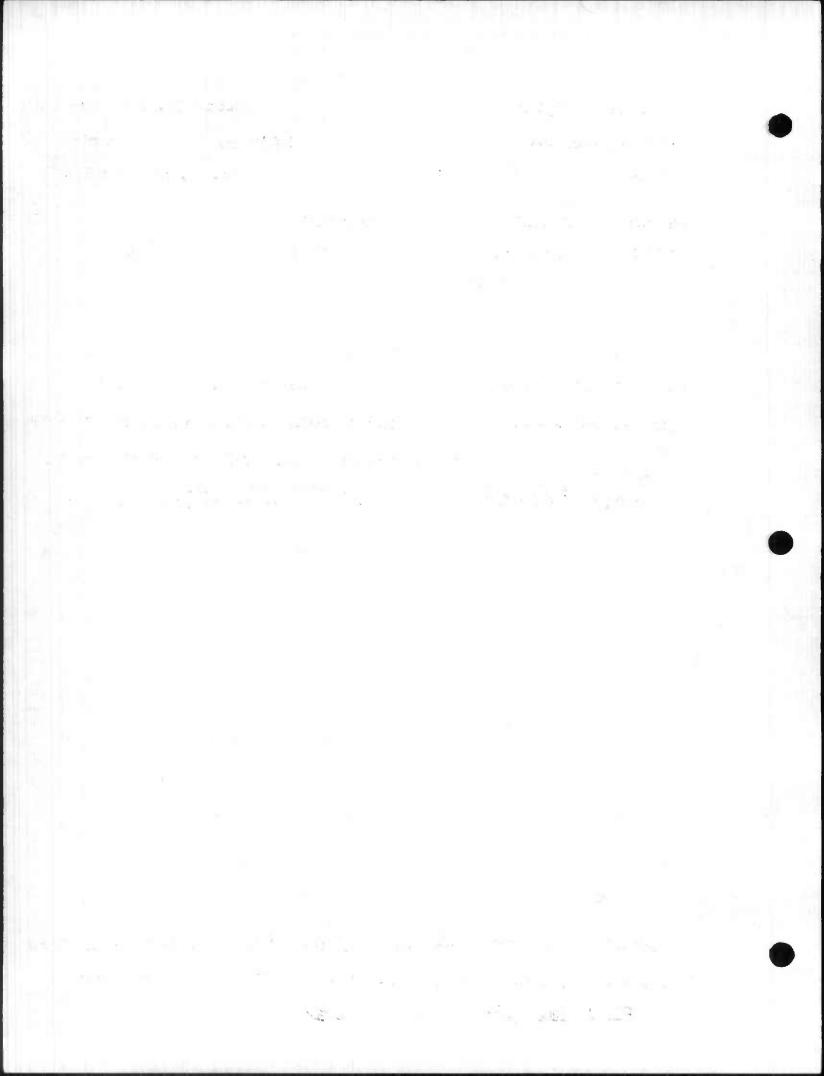
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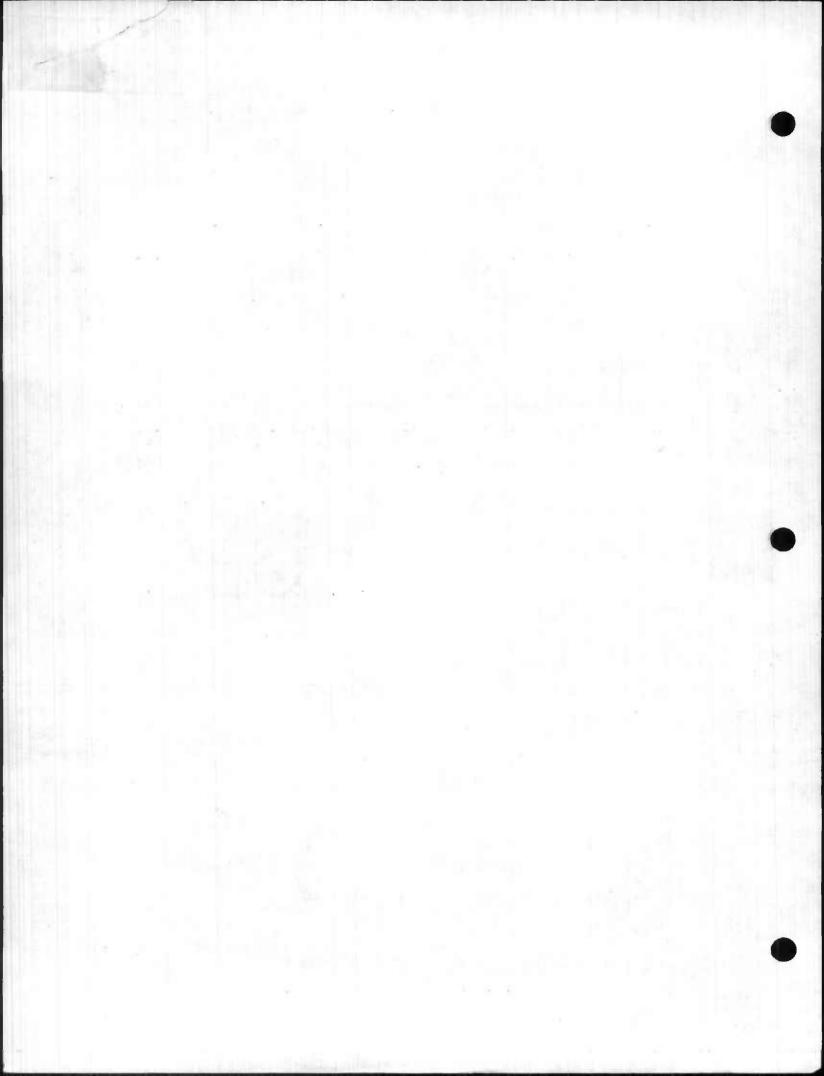
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| State of Maryland / Department of Health and Mental | Hygiene () | 0511 | |
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| | Physic | an | Decedent's Name (First, Middla, Last | ") | | | | | | 2. Dete of Deat Month | | | 3. Time of Deeth | | |
| 1 | /Medi | | Mildred Tay | lor | Jones | S | | | | January | 30°, 20 | QQ _a | 6:30 PM | | |
| | Exami | ner | 4e. Facility Nama (If not institution, give | street and number) | | | | | 4b. City, Town, or | Location of Deeth | 4c. County | | | | |
| | | М | 1625 Castleton Ro | | | | | | Darlir | | | larfor | d | | |
| | Funeral Director | | 5. Social Sacurity Number 6. Sa 213-12-9438 Usual Residance of Decedent | X 7. Ag | 91 (In yrs. | last birthday) Yrs. | Months | ar 1 Year Deys | Hours Min. | 8. Dete of Birth (Month, Day, Apr. 24 | , 1908 | 9. Birthpied Country Mary | Birthpieca (Stete or Foreign Country) Maryland | | |
| | land | | 10a. Stete 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | 10d | . Inside City Limits | | | |
| | the Marylan 28a-f show notived at | tor | Maryland Harf | ord | | | Fore | st H | i11 | | | | 1 ☐ Yes 2 🖁 No | | |
| | the road | rec | 10e. Street and Number | 024 | 1 | | | lp Code | | 1 | 0g. Citizen of V | Vhat Country | 7 | | |
| | ath with | Funeral Director | 1611 Denise Drive | | | | | | 1050 | | US | | | | |
| 21215-0020 | d within 72 hours after death with the Maryland ilene. Then "natural", or itema 23a or 28a-f show the Macrosi Examine must be notived at | by | 11. Maritel Status 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedant Armed Forces? 1 Yas 25 If Yas, Giva Yaar or Detes: | | | | edant of hecify Cub | dispanic Origin? (S an, Maxican, Puert Specify: | pecify Yas or No- o Rican, etc.) | | e - Amarican ek, White, etc | | | |
| 5-0 | "natural", | etec | 15. Decedent's Edu (Specify only highest grad | | | 16a. Dece | dent's Us | uel Occup | pation during most of wor | rkina | 16b. Kind of Bu | siness/Indus | stry | | |
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| Maryland | d 2 should be filed with th and Mental Hygiene. 7 Is marked other then traummatic event, the traummatic event, the traummatic event, the traummatic event. | | 17. Fether's Neme (First, Middle, Last) | Taylor | | | | | Louisa | ne (<i>First, Middle, I</i> G. | Meiden Sumam | Taylo: | r | | |
| Ž | should by and Menta marked imatic ev | P | | | | | | | | | | | | | |
| Ma | 7525 | | 19e. Informent's Name/Reletionship (7) | | | | | | and Number or Ru | | | | | | |
| | Heal Heal | | Wilson E. Bailey - | Son | 20h B | LU3 J | | | ille Rd. | | | | | | |
| Š | Ses To To | | XXBurial 2 Cremation 3 F | Removal from State | C | emetery, crei | matory or | othar pla | 1 | 250 | 20c. Location - | | | | |
| tim | nit. Pa infimen ortant: injury | | 4 □ Donetion 5 □ Other (Specify) | | Bel | el Air Memorial Grdns. 2/2/2000 Bel Air, Mary 22. Name and Address of Facility | | | | | | | aryland | | |
| Baltimore, | permit. Pa Departmen Important: any injury once. | | 21. Signature of Funeral Service sicens | meel | | M | icCon | as F | uneral Ho noadway, | | | and 2 | 1014 | | |
| | Physician | | 23e. Pert1. Entar the disease, or compl shock, or haart feilure. List only o | ications that caused na rause on each li | the daati ne. | h. Do not ant | er the mo | ode of dyir | ng, such es cardied | or respiretory arm | est, | A | pproximeta iterval Between inset and Death | | |
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| п | Examiner | | resulting in death) Due to (or es a consequence of): | | | | | | | | | | | | |
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| | rificate be executed ng physician and as the burial-transit | Examiner | Sequentially list conditions, | J | Due to (o | r es a consec | uence of |): | | | | | | | |
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| 387 | phys the | Physician/Medical | that initieted events resulting in deeth) Last | | Dua to (or | r as e conseq | uenca of |): | | | | | | | |
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| o | 0 0 2 | ysic | Pert II. Other algnificant conditions con | | ut not resu | ulting in the u | nderlying | causa giv | ven in Part I. | 23b. Dfd to | bacco use coi | ntribute to th | ne cause of death? | | |
| P.0 | that the dended by the a | | HYPERTEI | VSION | | | | | | 1 🗆 Yı | 2 No | 3 Probat | oly 4 ☐ Unknown | | |
| ds | sign d be | d by | | | | | | | | 24a. Was a | n autonou | 24h Ware | autopsy findings | | |
| of Vital Records, | law requires that the as been signed by th | Completed | | | | | | | | perform | ned? | availa | ible prior to letion of cause | | |
| Re | 0 - 0 | dm | | | | | | | | | 100 | of dec | | | |
| a | | | 05.14 | | | | | | | 1 □ Ye | W allower | 1 U Y | ′as 2□ No | | |
| ₹ | Physician: this certific rel director, | Be C | 25. Was case referred to medical examiner? | lospitel: | | | | Oth | | ith (Check only on | | | | | |
| | Phys | -: To | 1 Yes 2 No | 1 ku Inpatie | | ER/Outpetier 28b. Time of | | 28c. Injur | 4 LI INUISHING IT | oma 5 Reside | | | | | |
| on | tending Phy death. for: After thi | tion | 1 Natural 5 Pending | (Month, Da | Year) | Injury | м | Wor | k? Yes 2 □ No | 200. Describe in | w injury occurr | 60 | | | |
| 5 | Attending ir death. | lica | 3 Suicide 6 Could not be | 28e. Plece of Inj | ury - At ho | me fem str | | | 163 2 1110 | 28f. Location (St | reet and Numb | er or Rurel B | loute Number | | |
| - | X 2 = C | Certification: | 4 ☐ Homicide determined | building, etc | c. (Specify | /) | oai, iavio | ry, omce | | City or Town | , State) | or or ridiziri | oute reamber, | | |
| Ī | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by | edical C | 29a. Certifier (Check only one) (Check only one) | ner: On the basis of | exeminet | wledge, death tion and/or for | occurre vestigetio | d et the tir n, In my o | me, date end placa pinion, death occu | , end due to the co | ouse(s) and ma | nner es state | ed. a cause(s) | | |
| | the apple | Med | 29h Signeture and title of certifier | end menner ste | Hed. | | 20 | ac Licens | a number | 20 | 9d. Data signed | | | | |
| | 8 4 % 7 | | Andrew No | woll | sl | i wi | , " | 7 | 18090 | | | | 1,2000 | | |
| | • | | | | | | | | | | TIVE | 1 3 | 1,~000 | | |
| | 2 | | 30. Neme and eddress of person who co | empleted cause of d | eeth (Item | 23a) (Type, | Print) | V, K | IHN ST | . BEL | AIR, M | 02 | 1014 | | |
| F | Sta Registr | | 31. Dete filed (Month, Day, Year) FE 2 2001 | 32 Aegistra | ar's Signa | ture \mathcal{G} | E. | na H | 4 | | | | | | |





Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JOSEPH 31, 2000 4c. County of Death EART. Jenkins January 1:45pm 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) TALBOT WILLIAM HILL HEALTH CARE EASTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 ☐ F 96 Yrs. APR.23, 1903 WASHINGTON, DC 718-10-7531 Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2 □ No TALBOT EASTON MD 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 21601 USA 700 PORT STREET, APT. 115 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: WHITE **₹**DWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) VETERANS HOSPITAL ADMINISTRATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LAURA VIRGINIA RENNOE JOHN F. JENKINS 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7741 E. TAILSPIN LANE, SCOTTSDALE, AZ 85255 PAUL CHANEY/ GRANDSON 20b. Place of Disposition (Neme of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 2-7-00 CEDAR HILL CEMETERY SUITLAND, MD 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failura. List only one cause on each line. Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequenca of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yea 2 ☐ No 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Yes 2 No Other: 48 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

physician and s the burial-transit that the death certificate be assecuted Box 68760. 88 USB 9 6 Division of Vital Records. page 2 s certificate has or Attending Physician: After this funeral 24 hours after death.

Examiner Physician/Medical þ Completed Be 10 Certification:

Medicai

filled in by

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 26s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural, or than any injury or other traumetic event, the Medical Examples 2008.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

death

Director

Funeral

þ

Completed

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 14600

29c. License number

29d. Date signed (Month, Day, Year) 33/00

ellan 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

JR., M.D., 505 IDLEWILD AVENUE, EASTON, MD 21601 WILLIAM H. WOOD, 31. Dete filed (Month, Dey, Year)

State Registrar

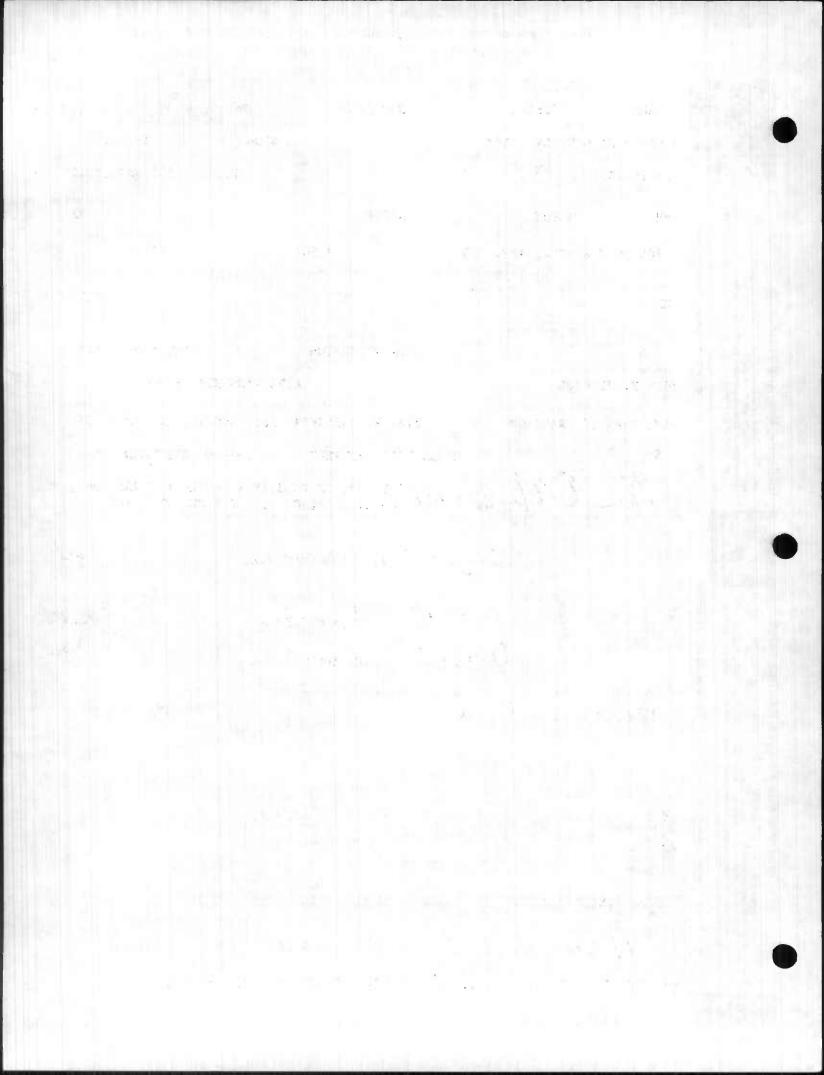
completely

within 2 943

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Hospital



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 5 0

| | | | Certificate of Death | leg. No. | | |
|------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--|--|
| | Physician | Decedent's Name (First, Middla, Last) | 2. Date of Dea Month | th 3. Time of Death | | |
| - | /Medical | Mildred Jackson | January | 23, 2000 5:15 P.M. | | |
| | Examiner | 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death Clinton | 4c. County of Death Prince Georges | | |
| | | Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last I | | | | |
| L | Funeral Director | | Yrs. Months Days Hours Min. Fe Dividity | 9. Birthplace (Stata or Foraign Was Wington, DC | | |
| | Pud am | | own or Location | 10d. Inside City Limits | | |
| | Many Many Tor | Maryland Prince Georges Clinton | on | 1 Yes 20 No | | |
| | ifter death with the Ma of Nema 23a or 28a-1a increment be recipied. Funeral Director | 10e. Street and Number 9106 Pineview Lane | 10f. Zip Code 20735 | 10g. Citizen of What Country? U.S.A. | | |
| 21215-0020 | by by | 11. Maritai Status 1 Never Married 2 Merried 1 Never Married 2 Merried 1 Yes 2 New A 1 Yes 2 New A 1 Yes or Detes: | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify: | 14. Race - American Indian, Black, Whita, etc. Specify: White | | |
| 5-0 | netural", | 15. Decedent's Education (Specify only highest grade completed) | 6a. Decedent's Usuei Occupation (Give kind of work dona during most of working | 16b. Kind of Business/Industry | | |
| 121 | E - E | Elementery/Secondary (0-12) College (1-4or 5+) | lifa. DO NOT usa retired) | Bank | | |
| 12 | Hygier the mrt. In Co. | 1 2 17. Father's Name (First, Middla, Last) | Secretary 18. Mother's Name (First, Middla. | | | |
| Maryland | Wate W | 1 6 4 1 1 | unobtainable | Maiden Sumame) | | |
| Jar | 200 | | 9b. Mailing Address (Street and Number or Rural Routa Numbe | | | |
| | 1 end Health em 27 other tr | | 012 Rhode Island Ave. Hyattsv | | | |
| Baltimore, | Page mr. H i my or | Cemai Cemai | of Disposition (Nama of tary, crematory or other place) incoln Crematory February 4, | 200. Location - City or Town, State 2000 Brentwood, MD | | |
| Balt | permit. Departn Importa eny Inju | 21. Signature of Funeral Service Licensee | 22. Name and Address of FacilityFt. Lincoln 3401 Bladensburg Rd. Brentw | | | |
| | Physician /Medical Examiner | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) | o not enter the mode of dying, such as cardiac or respiratory are | Onset and Death | | |
| | sit | Due to (or as a | a consequence of): | | | |
| 60, | death pertificate be executed e attending physician and d for use as the bunk-transit sician/Medical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | a consequence of): | | | |
| x 68760, | | resulting in death) Last Due to (or as a | a consequence of): | | | |
| Box | attendin Ifor use clan/N | 0 | | | | |
| P.O. | | Part II. Other significant conditions contributing to death but not resulting | 71 11 | obacco use contribute to the cause of death? 'ss 2 No 3 Perbably 4 Unknown | | |
| Records, | requires | Misease, Den | 24a. Was a perfor | | | |
| = | The page | | 1□ Y | es 2 1 Yes 2 No | | |
| VItal | sicien: The law certificate has t lirector, page 2 s o Be Comple | 25. Was case referred to medical axaminer? | 26. Place of Death (Check only or | na) | | |
| of | 후 분들 는 | 1 Yas 2 Hospital: 1 Impatient 2 ER/C | | | | |
| 5 | death. tor: Affer this the funeral cation: T | 1 Aatural 5 Panding (Month, Dey Year) | Injury Work? | ow injury occurred | | |
| Division | tal or Attending P rs after death. al Director: After t led in by the funer: Certification: | 2 Accident investigation 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify) | | treet and Number or Rurel Routa Number, n, Stata) | | |
| | To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by it Medical Certific | (Check only 2 Medical Examiner: On the basis of examination a | ge, death occurred at the time, date and place, and due to the cand/or investigation, in my opinion, death occurred at the time, d | ause(s) and manner as stated. late and place, and due to the cause(s) | | |
| | ithin 2 on the omple | one) and manner steted. 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) | | |
| | or will | · canal Illini | 1/ 021127/1 | 1,24,2000. | | |
| | | 30 Name and address of parent who are lived to the live of | 1) (Time Print) 27 2 4 (1/2) | 1 A B B 1/12 | | |
| | | 30. Name and address of person who completed cause of deeth (Item 23a | Blint MAN | 100 100 10-102 | | |
| | State | 31. Date filed (Month, Da), Year) 32 Registrar's Signature | 1 1. | - / /) | | |
| | Registrar | CCD-0 1 2000 Abuses | B fords | | | |

poor to process

FEB \$ 4 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 05 | 5 |

| | AMEND# | 1 | L2, 20B cmh AACO | Health | 2/1/0 | Certificate | of Death | | Reg. No. | U | 1 0 1 |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------|----------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------|--------------------------------------|--------------------------|-------------------------------------------------------------------------|
| | Physicia | n | 1. Decedent's Nama (First, Middla, Last, FREDERICU |) | | | | 2. Data of De Month | eth Day | Year | 3. Tima of Death |
| | /Medica Examine | - | 4a Facility Name (If not institution, giva ANNE ANCE | 0 - | 150 9 | WRR | 4b. City, Town, | or Location of Death | 4c. County | | muse L |
| | Funeral Director | | 5. Social Security Number 6. Se: | | (In yrs. last bin | thday) If Under 1 Months Yrs. | | Hrs. 6. Deta of Bir Min. (Month, Da | th ly. Year) | 9. Birthpl Coun | laca (Stata or Foraign try) yland |
| | anyland show data | | 10a. State 10b. County | | 10c. City, Town | | | | | 10 | Od. Insida City Limits |
| | the M | 8 | MARYLAND Anne A 10e. Street and Number | rundel | Annar | 00lis | ode | | 10g. Citizen of W | Vhat Coup | 1 Yas 2 No |
| | ier death with the Manylar flerma 23a or 28a-f ehow iner mans be notified at | Funeral Director | 916 Topmast Way | | | 214 | 01 | | USA | A | |
| 020 | or. or | 2 | 11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 [Yes 2] M If Yes, Giva Year or Datas: | 0 | | nt of HispanIc Origin? y Cuban, Mexican, Pu ⊋No <i>Specify:</i> X | ? (Specify Yas or No uerto Rican, atc.) | | White | atc. |
| 21215-0020 | within 72 hours af lene. then "naturel", or | Completed | 15. Decedent's Edu (Specify only highest grade | cation a <i>completed)</i> College (1-4or 5- | -} | | Occupation done during most of retired) | working | 16b. Kind of Bu | isinass/Ind | |
| | other th | | 17. Father's Name (First, Middle, Last) | | 141 | achinis | - | Neme (First, Middle | Railr | | |
| Maryland | 2000 | 200 | Frederick Johns | 3 | | | | red McMa | | 6) | |
| 7 | and Mente | To | 19a. Informant's Neme/Ralationship (Ty | roe, Print) | 19b | . Mailing Address (| Street and Number of | | | State, Zip | Code) |
| | nd 2 ; lith ar 27 le r trau | | Wanda J. Johns | Annapol | | | | | | | |
| ore, | ges 1 a it of Hear if hem or othe | | 20a. Method of Disposition | sere en arei | 20b. Place of | Disposition (Name | of | 1-29-00 | 20c. Location - | | |
| Imo | Pages nent of int: If he ury or o | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Othar (Specify) | | | | morial C | , – - 1 | | 1 . | - M.1 |
| Baltimore, | permit. Pag Department Important: I eny injury o page. | | 21. Signature of Funeral Service License | les . | | 22, Name end | Addrass of Facility | | | _ | vater, Md |
| | Physician /Medical Examiner | Je. | 23a. Pánt/Énter tha disease, or complishock, or heart fellura. List only or Immediata Causa (Final diseasa or condition rasulting in death) | | | | ol dying, such as carri | | T 22W | | Approximate Interval Batween Onset and Death THHED IATE |
| Box 68760, | ficate be physicians the bur | Physiciary medical Examiner | Sequentially list conditions, if any, laading to immediate cause. Enter Underfying Cause (Disease or injury that initiated evants rasulting in death) Last | c | Due to (or as a d | consequence of): | 7 / / / / | 1421 | | 1 | |
| | the death cer y the attendin sched for use | 200 | Part II. Other algnificant conditions con | ntributing to death but | t not rasulting in | tha underlying cau | usa givan in Part I. | 23b. Dld | tobacco usa cor | ntributa to | the cause of death? |
| s, P.O | v requires that the de been signed by the should be detached | Dy Pro | - H-yp | ismums | stino | Enja | | _ 10 | Yee 2□ No | 3 Prot | bebly 4 Unknown |
| Vital Records, | | Completed | - CENE | Snows | .C. D | \$. | | | an autopsy ormed? | ava | are autopsy findings allable prior to mpletion of cause death? |
| H | certificate has rector, page 2 | 5 | | | | | | 10 | Yas 2 No | 10 | Yas 2□ No |
| Vita | yalclen: is certific director, | 0 | 25. Was casa rafarred to medical axaminer? | lospital: | | | Other | Deeth (Check only | | | |
| ō | 2 00 | | 27. Mannar of Death 1 Invatural 5 Pending 2 Accident invastigation | 28a. Data of Injury (Month, Day | / 28b. T | | c. Injury at Work? 1 Yas 2 No | ng Home 5 ☐ Hesi 28d. Describe | dence 6 Other | | 0 |
| Division | To the Hospital or Attending Physibin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral | Certifica | 3 Suicide 6 Could not be detarmined | 28a. Ptace of Injurbuilding, atc. | | rm, street, factory, | office | 28f. Location (City or To | Street and Numb wn, Stata) | er or Rura | l Route Number, |
| | ne Hospit n 24 hour ne Funera pletely fills | | 29a. Certifier (Check only 2 Medical Country | ner On the basis of a | xaminetion and | , deeth occurred et d/or invastigation, i | the time, data and pl n my opinion, daath o | ace, and due to the occurred at tha tima, | cause(s) and ma data and ptece, a | nner as st and dua to | ated. tha ceusa(s) |
| | To the comp | | 29b. Signature and fittle of continer | 1 | | 29c. | Licensa number | | 29d. Data signed | | |
| | | | | 1 | | | >5674 | - (| 01- | 27 | 1-00 |
| | | | 30. Name and address of person who co | mpleted cause of de | | 1 1 | ric Sala | ta MD | M | 2 | 1041 |
| | State Registra | | 31. Data filed (Month, Day, Year) | 32. Registrar | r's Signatura | 4 1 | 20.16.1 | | | | |

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State of Maryland / Department of Health and Mental Hygiene \(\Omega\)

| | | , | C | ertifica | te of l | Death | , | Reg. No. | 7 02127 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------|--------------------------------|----------------------------|----------------------------------------------------|-----------------------------------------|------------------------------------|--------------------------------------------------------------------------------------|
| Dhusisian | 1. Decedent's Neme (First, Middle, La. | st) | | | | | 2. Date of De Month | | 3. Time of Death |
| Physician /Medical | Mary Jane | Jones | | | | | Jan. 28 | | 11:57 AM |
| Examiner | 4a Facility Neme (If not institution, give | e street and number) | | | 4 | b. City, Town, or | Location of Deat | h 4c. County | of Death |
| | 3010 Curtis Dr. | | | | T | emple Hi | lls | Princ | e Georges |
| Funeral Director | 5. Social Security Number 6. S 398–18–5337 Usuel Residence of Decedent | Pex 2/OXF 7. Age (In | yrs. last birthd 75 Yrs | Month | er 1 Yeer Days | If Under 24 Hrs Hours Min | 8. Dete of Bir (Month, Da Oct. 19 | th. Year) 9,1924 | 9. Birthplece (State or Foreig Country) Wisconsin |
| P 8 11 | 10a. State 10b. County | 10c | . City, Town or | Location | | | | | 10d. Inside City Limits |
| with the Marylan a or 28e-f show be notified at Director | Maryland Prince (| Georges | | Temp1 | | ls | | | 1 🗆 Yes 230 No |
| ath with a | 3010 Curtis Dr. | | | | 2074 | | | | USA |
| marylana ZIZIS-00Z0 d2 should be fled within 72 hours after death v th and Mental Hygiera in attenty, or teams 23a traumetic event, the Medical Examiner must To Be Completed by Funeral | 11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in Armed Forces? 1 Yes 2 Xes One if Yes, Give Year or Dates: | in U,S. | | | ispanic Origin? (S n, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | | e - American Indien, ck, White, etc. White |
| ed within 72 ho regiens. we than "natural, the Medical. | 15. Decedent's Ed (Specify only highest gra | ducation de completed) | (G | cedent's Us | vork done o | during most of wa | rking | 16b. Kind of B | usinass/Industry |
| 4 4 B | Elementery/Secondery (0-12) | College (1-4or 5+) | - life | e. DO NOT | use retired |) | | | |
| Co thinks | | 4 | Acco | untin | g Tec | hnician | | 1. | Government |
| Be seem | 17. Father's Neme (First, Middle, Last) | | | | | | me (First, Middle | | ne) |
| Mental Man | Guy E. Dillie | | | | | | Griff: | | |
| EBNE | 19e. Informent's Neme/Relationship (| | | | | Makesar | | | State, Zip Code) 146 |
| omit. Pages 1 a lepartment of Her moorlant: If Ihem ny Injury or othe ISSE. | 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification of the control o | 20c. Location - | City or Town, Stete | | | | | | |
| permit. Departe imports any inju | 21. Signeture of Funeral Service Licer | las | | Georg | e P. | ss of Facility Kalas Fu Hill Rd | | | |
| | 23a. Pert/. Enter the disease, or com shock, or heart failure. List only | plications that caused the c | | | | | | | Approximate Interval Between |
| entificate be associated ding physician and se as the burist-transit and Medical Examiner | disease or condition resulting In deeth) Sequentietly list conditions, if any, teeding to immediate cause. Enter Undertying Ceuse (Disease or Injury that initiated events resulting in deeth) Last | b. Hype | to (or as a con | sequence of | 1): 3 XV 1): 1 E1 | mi A | | | 12 Jea |
| death cert death cert death cert death cert death cert | | | | | | | | | |
| es that the death certificated by the attending be detached for use aby Physician/M | Pert II. Other significant conditions of | ontributing to death but not | resulting In th | e underlying | cause giv | en in Pert I. | | | ntribute to the cause of death |
| | | | | | | | 10 | Yas 2 No | 3 Probably 4 Unknow |
| requir seen s should | | | | | | | | an autopsy ormed? | 24b. Ware autopsy findings available prior to completion of cause of death? |
| stolan: The law certificate has to lirector, page 2 s | | | | | | | 10 | Yes 2 No | 1 Yas 2 No |
| certificate rector, pa | 25. Was case referred to medicat | | | | | 28. Place of De | eth (Check only | one) | |
| Physician: this certific ral director, | axaminer? 1 | Hospitel: | 2 ER/Outpa | tient 30 [| OOA Oth | or: | Home 5 TResi | | ner (Specify) |
| sa 3 | 27. Manner of Death 1 12 Netural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Yea | 28b. Tim | e of | 28c. Injun Work | | | how injury occur | |
| tal or Attending P rs after death. at Director: After led in by the funer Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Plece of tnjury - / building, etc. (Sp | At home, ferm, ecify) | street, fecto | ory, office | | 28f. Location (City or To | Street and Numb wn, State) | ber or Rural Route Number, |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification | 29a. Certifier (Check only one) 2 Medical Exam | yelclan: To the best of my niner: On the besis of exam and manner steted. | knowledge, de ninetion and/or | eth occurre r investigation | d at the timen, in my of | ne, dete and ptec pinion, deeth occ | e, end due to the urred at the time, | cause(s) end me date end place, | enner es stated. and due to the cause(s) |
| M M | 29b. Signature and title of cedifier 29c. License number | | | | | | | 29d. Dete signe | d (Month, Day, Year) |
| (10) | 1 Resal | | | 7)35 | -656 | | 01/2 | 7/00 | |
| (0) | 30. Name and address of person who of Karl Salman, M.D. | | | | , Can | np Sprin | gs, MD 2 | 0746 | |
| State Registrar | 31. Date filed (Month, Day, Year) FES 0 1 2000 | 32 Finglistrer's Si | | | - | | | | |

DHMH 16 Ray 6/95

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| | | State of | Maryland / | | nent of F cate of | | | | Reg. No. | 0 | 5153 |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------|------------------------------------|------------------------------------|-------------------------|--------------------------------------------------------------------------|
| | 1. Decedent's Name (First, Middle, L. | ast) | | | | | | 2. Date of De | ath | | 3. Tima of Death |
| Physician | Costamaine | J. Johns | son | | | | | Januar | y 30, 2 | 000 | 5:11am |
| /Medical Examiner | 4a Facility Nama (If not institution, gi | ve street and numb | ber) | | | 4b. City, To | wn, or L | ocation of Death | ition of Death 4c. County of Death | | |
| | Prince George | e's Hospi | tal | | | Che | ver1 | .y | Princ | e Geo | orge's |
| neral | | | . Age (in yrs. last l | | Under 1 Year | If Under Hours | 24 Hrs. Min. | 8. Data of Birt | h v Year) | 9. Birthe | placa (State or Foreign |
| ctor | 579-78-1378 | 1□M 225F | 45 | Yrs. | inis Days | Hours | POTINI. | June 15 | , 1954 | Wash | nington, D. |
| | Uaual Residence of Decedent 10a. Stata 10b. County | | 100 Ciby To | wn or Locatio | • | | | | | | Od Inside City Limits |
| y Funeral Director | Tod. Stata | | | | | 170 V | | | | | 10d. Inside City Limits 1 No 2 No |
| oct | 10e. Street and Number | | Was | hingto | | | | | 40 - O'ilaa41 | | |
| 급 | | C T | | | of. Zip Code | 0010 | | 10g. Citizen of What United | | | • |
| era | 4117 Beck Stree | 12. Was Deced | ant Euros in II C | 12 Man | 20019 | | | poih. Vas as Na | | ce - Americ | |
| by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Force 1 Yes 2 If Yes, Give | Armed Forces? 1 ☐ Yes 2 ☑ No | | Was Decedent of Hispanic Origin? (Spir Yes, specify Cuban, Mexican, Puerto □ Yes 2 ☑ No Specify: | | | Rican, atc.) | | ck, Whita, | atc. |
| 8 | 15. Decedent's E | | | | Usual Occur | pation | - | | 16b. Kind of B | usiness/in | dustry |
| Completed | (Specify only highest gi | ade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of worlden by the book of the boo | | | t of work | ing | | | |
| E | Elementary/Secondary (0-12) | College (1-4 | 1 | | Homemaker | | | | Domestic | | |
| Be C | 17. Father's Nama (First, Middle, Las | t) | | 18. Mother's Nam | | | | | Maiden Sumar | ne) | - 477-2 |
| 0 | Melvin Jacobs | | | Franki | | | | | e | | |
| | 19a. Informant'a Name/Ralationship | (Type, Print) | 15 | b. Mailing Ad | idress (Street | and Number | er or Rui | al Route Numbe | er, City or Town | State, Zip | Code) |
| | Cedric Johnson | /Husband | 4 | 117 Be | ck St. | S.E. | Wa | shingto | n, D.C. | 200 | 019 |
| | 20a. Method of Disposition | | 20b. Place | of Disposition | (Name of | | | Data | 20c. Location | | own, Stata |
| | 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci | | ate | nwood | | | 12 | 2/5/00 | Washir | gton | , D.C. |
| | 21. Signature of Jurieral Service Lice | Francisco I | eral Homes | | | | | | | | |
| | I aller de | Par to |) | | | | | runera. Forest | | W.J | 20747 |
| Medical Examiner | diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b | Due to (or as a Due to (or as a | consequenc | e orj. | re | | 74710 | | | |
| Physician/M | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | 23b. Dld | lobacco uea co | ontribute t | o the cause of death? |
| by Phy | | | | | | | | 10 | Yes 2□ No | 3 Pro | bebly 4 Unknown |
| Completed b | | | | | | | | 24a. Was perlo | an autopsy med? | av | era autopsy findings allable prior to impletion of cause death? |
| E O | | | | | | | | 10 | ras 2 No | 11 | □ Yas 2□ No |
| | 25. Was casa refarred to medical | | | | | 26. Place | of Deal | th (Check only o | nne) | | |
| ToB | examiner? 1 ☐ Yas 2 ☒ No | Hospital: | patient 2 ER/C | Outpatient 3 | DOA O | her | | ome 5 Resid | | her (Specia | (y) |
| Certification: | 27. Manner of Death 1 🖾 Natural 2 🗀 Accident 5 🗀 Pending investigation | on | Injury Day Year) 28b | . Tima of Injury | 28c. Inju Wo | ryat rk?]Yes 2□ | No | 28d. Describe | now injury occu | rred | |
| Sertific | 3 Suicide 6 Could not I determined | f Injury - At homa, , etc. (Specify) | farm, street, f | actory, office | | | 28f. Location (: City or Tox | | ber or Run | al Route Number, | |
| edical C | 29a. Certifier (Check only one) Certifying P | hysician: To the be miner: On the basi and manne | is of examination a | ge, death occ and/or investig | urred at the ti pation, in my o | me, date an opinion, dea | nd place, ath occur | and due to the red at the tima, | cause(s) and m date and place, | annar es a and dua t | stated. the cause(s) |
| Medical Ce | 29b. Signature and title of certifier | 4 | 7 1. | | 29c. Licens | | | | 29d. Data signe | ed (Month, | Day, Year) |
| | to Ma | + C. | An A | MI) | DA | 129 | 50 | | Jan. | 30. | 2000 |
| | 30. Name and address of person who LaMart C. Sm | | |) (Type, Print Hospit | | | | y, Md. | | | |
| | 31. Date filed (Month, Day, Year) | 22 0-4 | istrar's Signature | | | | | | | | |

DHMH 16 Rev 6/95

28 miles 18
LARON 31. Date filed (Month, Day, Year) FEB 0 3 2000 State Registrar

LOCKE, UM

end address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

O.C.M.E

JAN. 26, 2000

0001 - 333

The state of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 5 1 5 5

| | | | | | | | 1 111100 | ILO OI | Death | | | Reg. No. | | | |
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| | _ | Decedent's Nem | ne (First, Middle, La | ist) | | | | | | | | 2. Data of Death Month Day Year | | | of Death |
| /sician ledical | _ | | Wi | lliam S. | Jones | 3 | | | | | January | 20 2 | 2000 | 11: | 25 PM |
| aminer | | Facility Nama (| If not Institution, give | | | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. Coun | ty of Death | | |
| | ı | VA Mary | land Heal | th Care | Syste | m | | | Perry | | nt | Ceci | L | | |
| eral | 5. | Social Security N | | Sex 1□XM 2□ F | 7. Age (In yrs | . last birthday |) If Und Month | er 1 Year Days | If Undar Hours | 24 Hrs. Min. | 8. Data of Birt (Month, De | h y, Year) | 9. Birth | place (Stel | e or Foreig |
| tor | | 25-16-10 suel Residence of |)78 | ILAM ZUF | 79 | Yrs. | | | | | Jan. 17 | | | inia | |
| rector | | Da. Stata | 10b. County | | 10c. C | ity, Town or L | ocation | | | | | | | 10d. Inside | |
| , ot | M | aryland | Anne Ar | undel | | Riva | ı | | | | | | | 1 🗆 Y | 98 2 N |
| Directo | 10 | a. Street end Nu | mber | | | | 10f. 2 | Ip Code | | | | 10g. Citizen o | 0g. Citizen of What Country? | | |
| alc | | 206 Map1 | e Road | | | | 21140 | | | | | USA | | | |
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| by | | 1 Nevar Marr | ried 2 Married 4 Divorced | Y Yes fi Yes, Give Yaer or De | 2 No | | | Ž No | Specify: | | | Spec | | ite | |
| Completed | | | 15. Decedant's E | | | (Give | 16a. Decedant's Usuel Occupetion (Give kind of work dona during most of work) life. DO NOT usa retired) | | | | ing | 16b. Kind of | Business/Ir | ndustry | |
| Be Comple | | Elamantary/Seco | | College (1 | -4or 5+) | | | | a) | | | | | | |
| ទ | | 8th | 457 | | | Pi | ledr | iver | 40.00.00 | | (Flora Mildallo | Heavy | | struct | ion |
| B | í | | (First, Middle, Last | • | | | | | 18. Moth | | e (First, Middle, | | | | |
| P of | | | scar Gile | | | 1 | | | | | rgianna | | | | |
| | | | ame/Relationship | | | | | | | | el Route Numbe | | | p Code) | |
| | - | Judith A. Moody/ Daughter 208. Method of Disposition 20b. Plec | | | | | - | laple Road Riva, Maryland 21140 | | | | | Canal | | |
| any injury or other traumatic once. | 20 | 1 DB Buriel 2 | cem etery, cre | emetory o | r other ple | | i | | | | | | | | |
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| DUC. | 2 | 1. Signature of Fu | uneral Service Lice | nsee | | 2 C | 2. Name | end Addre | Kalas | ty Fur | neral Ho | Ome. | | | |
| 2 9 | | Mulau | MILLIS | | | 2 | 2973 | Solo | nons | [s]ar | nd Rd. I | Edoewat | er. M | ID 210 | 37 |
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| an | | snock, or nea | art failura. List only | one causa on a | ach ma. | | | | | | | | | Onsat ar | d Death |
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| prietary lined in by the functial director, page 2 should be certached for use as the bungi-franking edical Certification: To Be Completed by Physician/Medical Examiner | d re | isaase or conditions and its control of the control | onditions, mediate arriving injury s Lest ficant conditions of the state of the st | b. Con c. Dia d | Due to Du | (or as e conse | equance of the Fa equance of the Fa equance of the Fa equance of the Equanor of the Fa equanor of the Fa equanor of the Equano | ilure ilure f): j cause gi 26. Plecher: 4 No. 17 y at rk? Yes 2 Man, dete eropinion, detes a number | e of Deat ursing Ho | 23b. Did 1 | en eutopsy med? Yes 2 Moona) dance 6 Cohow injury occ Street end Nur wn, Stefa) causa(s) and date end plec | 24b. Van Cool of the Cool of t | Unkno Unkno to the cause to the cause obably Vara autop valiable pri ompletion of death? Yes ithy) rel Route A steted. to the cause o, Day, Yes | WIN WIN WIN WIN WIN WIN WIN WIN |

DHMH 16 Ray 6/95

March 18

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** Michael Anthony Kopec 02 10 2000 7:25PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Stella Maris Hospice Center Timmonium Baltimore If Under 1 Yeer | If Under 24 Hrs. Months | Devs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Pey, Year) 09/14/1948 9. Birthplece (Stete or Foreign Country) New Jersey Funeral Months Hours 10XM 20 F Deys 51 136-38-1899 Director Usual Residence of Decedent 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 27 Shawnee Court 21234 APT 304 Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? 1 ②Yes 2 □ No If Yes, Give Yeer or Dates: 1967-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 'natural', or har idical Examiner 1 Never Merried 2 Merried 1 Yes 2 No Specify: White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Automotive Retail Manager 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Louis Harzenski Kopec Alice 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Kopec Wife 27 Shawnee Ct. Apt 304 Department of Health. Important: If Ilem 27 Is any injury or other tra Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or ofher place) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State American Cremation 02/15/00 4 Donetion 5 Other (Specify) Warwick. 22 Name and Address of Fecility Lisiecki Memorial Home 21. Signature of Fitners Service Licente 1028 N. Marily M00984 Olden Ave Trenton, Meloni 08638 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. Liet only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical LIVER CANCER Examiner Due to (or as a consequence of) Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequenca of) 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖹 Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy tindings evailable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify HOSPICE Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one)

within 2 State

After

24 hours after death.

Funeral Director: A

or Attending

Hospital

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23a-f

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Berns 23a

filed within 72 hours after Hygiene. Over then "natural", or lies

Pages 1 and 2 should be nent of Health and Mental

the death certificate be executed

Box 68760.

P.0.

Records, Kopec

of Vital

Division

Michael

Maryland 21215-0020

Baltimore,

2000

February

Registrar

DHMH 16 Rev 6/95

FEB 19 2000

DR. TARIQ MAHMOOD

011-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

29c. License number

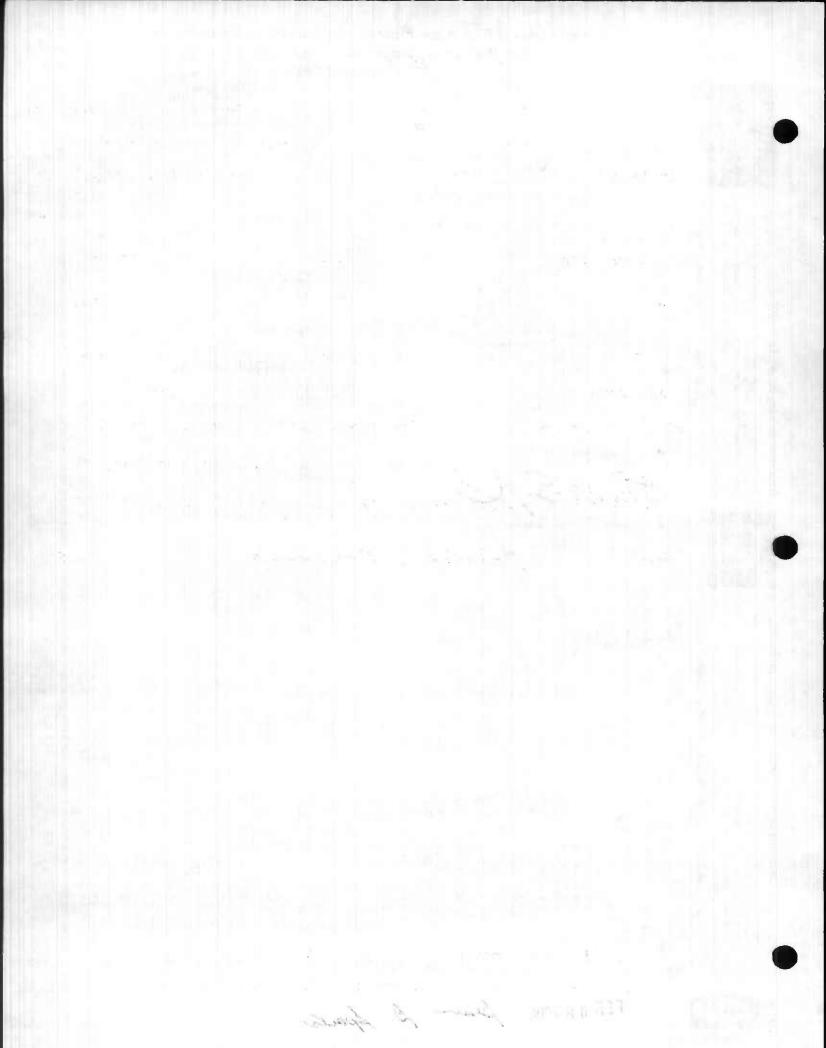
D43725

29d. Date signed (Month, Day, Year)

2/11/00.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | Decedent's Name (First, Middle, | act) | Certific | ate of | Death | 2. Dete of De | Reg. No. | 3 1 | ima of Death | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------|--------------------------------|------------------------------------|----------------------------|--|
| Physician /Medical | Michael | М. | Kravats | | th City Town as less | Month Februa | ery 6, 2 | Year 000 9:4 | 40 a.m. | |
| Examiner Funeral Director | 209-09-1417 | 1 Drive | Mor | nder 1 Year | Mechanics If Under 24 Hrs. Hours Min. | sville 8. Date of Bir (Month, Da | St. | Mary's | Stete or Foreign Lvania | |
| yland | Usual Residenca of Decedant 10e. State 10b. County | 100 | c. City, Town or Location | | | | | 10d. In: | side City Limits | |
| the Merylar 28s-f show course | PA Greene | | Mather | | | 1 DY | | | | |
| with the or 2 | 10e. Street and Number | | 10 | . Zip Code | . 6 | | 10g. Citizen of V | | | |
| ife, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Meryland Heelth and Mental hygiene. tten 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic avent, the Medical Exercited and To Be Completed by Funeral Director | | 12. Wes Decedent Ever Armed Forces? | If Yes, | 1534 ecedent of t specify Cub | Hispenic Origin? (Spe en, Mexican, Puerto F | cify Yes or No Rican, etc.) | - 14. Raci | a - American Ind k, White, etc. | ite | |
| aryland 21215-0020 should be filed within 72 hours at d Mental Hygiane. marked other than "naturel", or imatic avent, tra Modical Exam To Be Completed by F | 15. Decedent's (Specify only highest (Elementary/Secondary (0-12) | Education rade completed) College (1-4or 5+) | | Usual Occup If work done OT use retire Miner | pation during most of workir d) | ng | | winess/Industry | | |
| nd 2 be filed tother went, to | | st) | COal | MIMEI | 18. Mother's Name | | - | | | |
| Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic avent | | (Time Point) | Antio | onette | | State Zin Code | 1 | | | |
| Baltimore, Mar. Depart and 2 sho Department of Heelth and Important: if item 27 is ma nay injury or other traum | Michael M. Krava 20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Spe | ts / Son | | Orest (Name of or other pla | Hall Dr., | Mechar | nicsvill | e, MD 20 City or Town, S | 0659 tate | |
| Baltimory pemit. Pagas Department of P important: If its any injury or of ange. | 21. Signature Viteral Sept. 1. LdwaYd N B T I 23a. Pert1. Enter the diseese, or co | Bulleld, Jr.M | 22. Nan 100052 2295 | s Ho1 | ess of Facility 1ywood Roa | ıd, Leo | nardtow | n, MD 20 | | |
| Control of the contro | | c | to (or as a consequence | ı ot): | 4Udm A | | | | et and Death | |
| daath certif e attending od for use a | | d | | | | | | | | |
| hat the detached | Part il. Other significant conditions | contributing to death but no | t resulting in the undarly | ing cause gi | iven in Part I. | | tobacco use co Yes 2□ No | 3 Probably | 4 Unknow | |
| s been 2 should | | | | | | | s an autopsy ormed? | avallable | on of cause | |
| : The is cate he | | | | | | 10 | Yas 2100 | 1 🗆 Yes | 2000 | |
| Of VITAL Physician: The Physician: The certificate ral director, page TO Be Co | 25. Was case referred to medical examinar? 1 Tyes 2 No | Hospitat: | 2 ☐ ER/Outpatient 30 | DOA OI | 26. Place of Death her: 4 Nursing Hor | | | er (Spacify) | | |
| Ming Ph. Aftar thi funaral | 27. Manner of Death 1 Natural 5 Panding 2 Accident investigal 3 Suicide 6 Could no | 28a. Date of Injury (Month, Day Yea | 28b. Tima of Injury | 28c. Inju | rry at ork?] Yes 2 □ No | Home 5 ☐ Residence 6 ☐ Other (Spacify) 28d. Describe how injury occurred | | red | | |
| To the Hospital or Attent within 24 hours eitar dealt To the Funeral Director: complataly filled in by the Medical Certifical | 4 Homicida datamini | building, etc. (S) | | | | City or To | (Street and Numb wn, State) | | te Number, | |
| To the Hospital or within 24 hours efts to the Funeral Dir complataly filled in Medical Cert | | Physician: To the best of my aminar: On the basis of exal and manner stated. | | | | | | | cause(s) | |
| To the compla | 29b. Signature end titla of certifiar | no tamo | | | se number 014285 | | 29d. Dete signe | d (Month, Dey, | Year) | |
| 4 | 30. Nama and addrass of person with William D. Boyd | • | | | | own, MI | 20650 | | | |
| State Registrar | 31. Data filed (Month; Dey, Year) | 32. Registrar's S | | Some | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death 1. Decedent'a Name (First, Middle, Last) 3. Time of Deeth February 7, 2000 Charles 6:30 PM Kuchta 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) May 28, 1916 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Yrs. 83 282-10-0077 Pennsylvania Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 22680 Cedar Lane Apartments 20650 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: 3 ₩ Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9th Steel Worker Steel 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Charles Herbert Kuchta Helena Kukulak 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 48492 Evergreen Park Road, Lexington Park, MD 20653 John Martin Kuchta/ Grandson 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABuriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Michael's Cemetery 2/12/00 Newton Falls, Ohio 22. Name and Address of Fecility. Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee of love Vardina P.O. Box 270, Leonardtown, Maryland 20650 233. Pert1. Enter the disease, or complications that caused the deut. To not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Finet disease or condition resulting in deeth)):brillation · Ventucular Due to (or as e consequenca of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yae 2 ☐ No 3 ☐ Probably 4 X Unknown Chunce Obx fruction Lung Discos 24b. Were eutopsy findings aveilable prior to Parkinsons Deseas 24e. Wes en eutopsy performed? completion of cause of death? Dementia 1 ☐ Yes 2 🔯 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZENo 28b. Time of Injury 27. Manner of Deeth 28a. Dete of fnjury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 4 Homicide Cautying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certitlei (Check only one)

certificate be executed P.O. Box 68760, Division of Vital Records, or Attending efter death. Hospital 24 hours

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is merked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Exercises.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

signed by t

page 2 s

After this

funeral

á

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

Medical

State

Registrar

31. Date fited (Month, Day, Year)

30. Neme and address of persi

29b. Signature and title of certifie

32. Registrer's Signature

nwho completed cause of deeth (Item 23e) (Type, Print

FEB 0 9 2000

John F. Fenwick, M D

B. Sports

Leonardtown, Maryland 20650

29c. License number

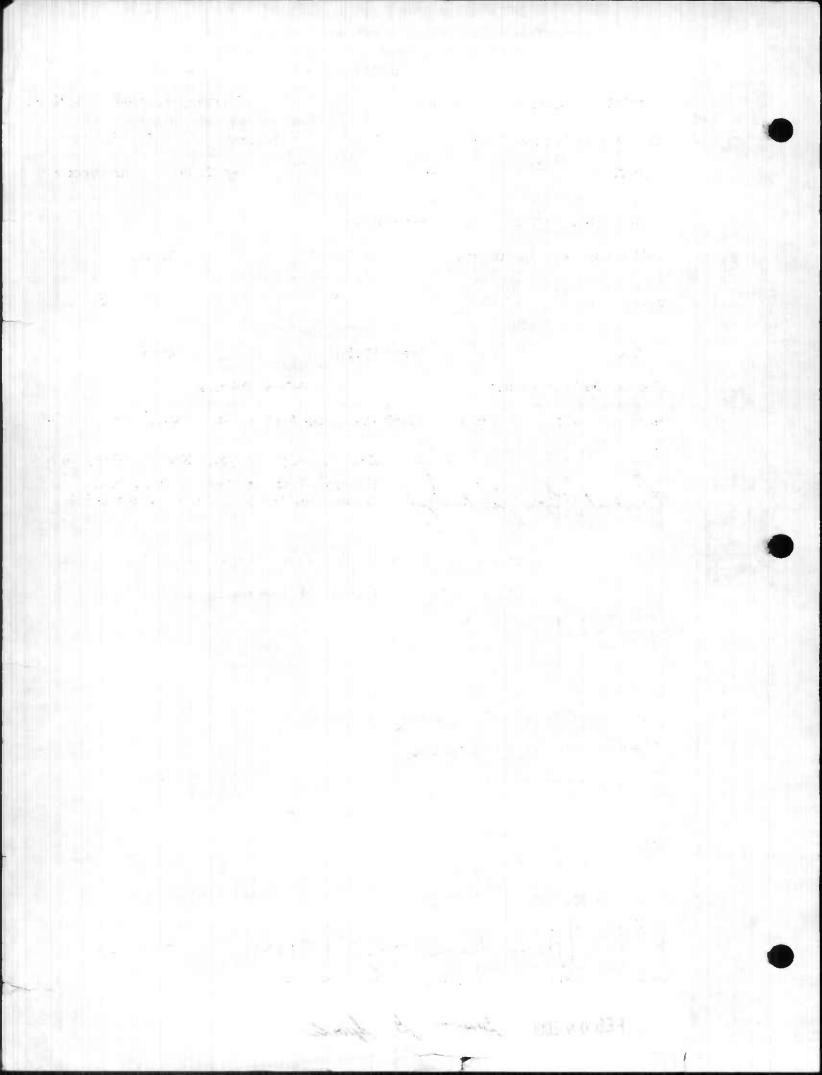
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29d. Date signed (Month, Day, Year)

2-8.

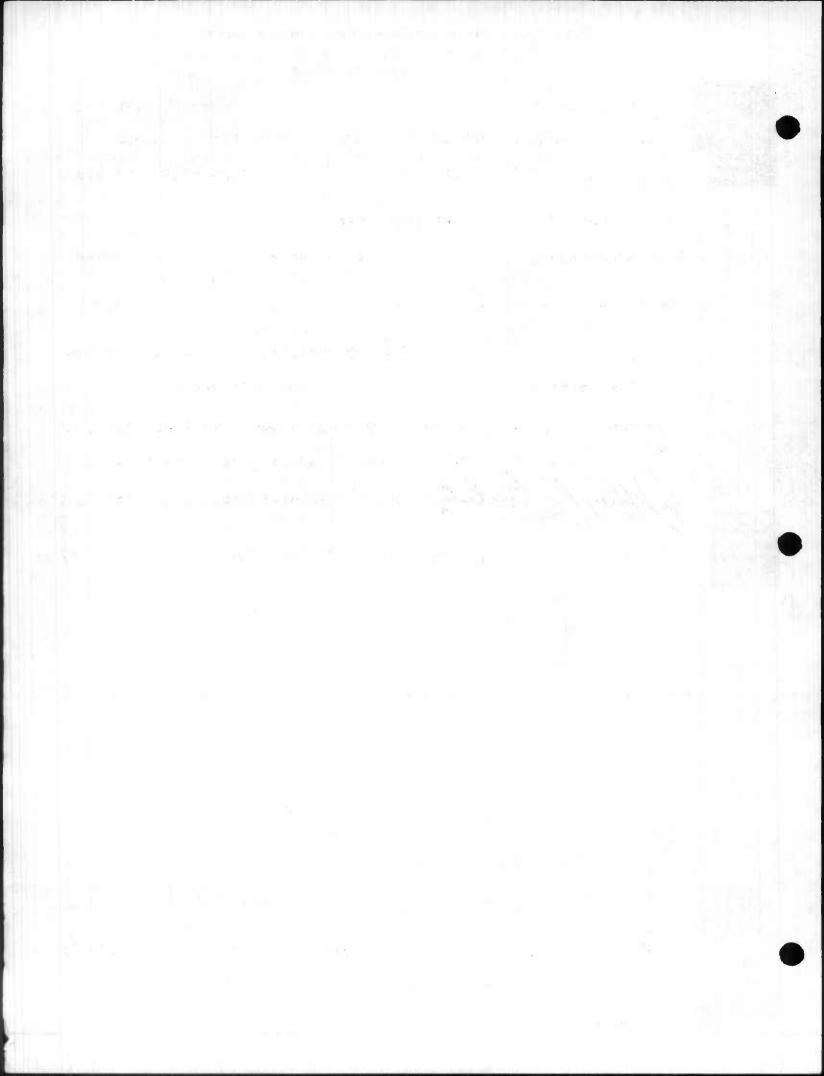
DHMH 16 Rev 6/95

To the within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

| | | | | | State of M | , | | ficate of | | | Reg. No. |) U | 010 | 9 | | |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------|-----------------------------------------|-------------------------------|---------------------------|---------------------------------------------------|------------|--|--|
| | Physici | an | Decedent's Name | | | | | | | 2. Dete of De Month | _ | Year | 3. Time of | | | |
| U | /Medic | | | E. Kror | | | | | | Januar | | | 9:30 | P.M. | | |
| | Examir | ner | | | ve street end number) sing And Re | ehabili | tatio | | 4b. City, Town, or Ellico | tt City | h 4c. County HOW | | | | | |
| Н | Funeral | | 5. Social Security Nu | | | e (In yrs. last l | | f Under 1 Year lonths Days | If Under 24 Hrs Hours Min | | th v. Year) | 9. Birthp | lace (Stete o | or Foreign | | |
| | Director | | 185-28- | 1366 | 1□M 2XF | 91 | Yrs. | Days | 110010 | 10/5/ | 1908 | Mar | y1and | £ | | |
| | and w | | Usuei Rasidanca of I 10a. Stete | 10b. County | | 10c. City, To | wn or Locati | ion | | | | 11 | 0d. Inside Ci | ity Limits | | |
| | Mary | tor | MD | Howard | 1 | E11 | icott | City | | | | | 1 X Yes | 2 No | | |
| | r 28a | Director | 10e. Street and Num | ber | | | | 10f. Zip Code | | | 10g. Citizen of Whet (| | | | | |
| | th wil | | 5109 Av | oca Ave | enue | | | 2104 | 3-6614 | 14 Unite | | | ates | | | |
| | tome to me | Funeral | 11. Merital Status | | 12. Was Decedent Armed Forces? | | 13. Was | Decedent of H | lispanic Origin? (5 en, Mexican, Puer | Specify Yes or No to Rican, etc.) | | e - Americ | | | | |
| 20 | ', or i | by F | 1 ☐ Never Marrie 3 ☑ Widowed 4 | | 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | No | 10 | Yes 212 No | Specify: | | Specify | Whi | +0 | | | |
| 0 | 72 hours after death with the Maryland "neturel", or items 23e or 28e-f show of eal Evertiret must be notified at | | | 15. Decedent's E | ducation | 16 | a. Decedent | t's Usuel Occup | eation during most of wo | | 16b. Kind of Bi | | | | | |
| Maryland 21215-0020 | 5 . | Completed | (Specifi Elamentary/Secon | fy onfy highest grand | ade completed) Collega (1-4or 5 | | (Give kind life. DO | d of work done NOT usa ratired | during most of wo d) | rking | | | , | | | |
| 2 | 17 170 4 | Co | 12 | | | , | Phot | o Tec | hnician | | Civil | | vice | | | |
| and | A a a | Be | 17. Father's Neme (F | | , | | | | | ma (First, Middle | | ne) | | | | |
| Ž | d 2 should be th and Mental 7 is marked o traumetic ave | 2 | 19e. Informent's Ner | r Leath | | | Gertrude Myers 9b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2 | | | | | | 0.4.1 | | | |
| Ma | d2 s th ar 7 in frau | | | | | | | | | | | | | | | |
| re, | F Haz | | 20e. Method of Dispo | | er - Dau | 20b, Placa | of Disposition | on (Neme of | ca Aven | ue, El | 20c. Location - | _C1.t | y , MD wn, State |) | | |
| E | Pages nent of I nt: If ite iry or o | | | Cremetion 3 ☐ 5 ☐ Other (Special | Removel from Stete | | | ory or other plea de Cei | metery | 2/4 | Delta | lta,PA | | | | |
| att | permit. Page: Department of Important: If i any Injury or ance. | | 21. Signature Fun | neral Service Lice | nsee | 1.1 | | ame end Addre | | -/. | DCIO | , | No. | | | |
| 0 | 88 = 88 | | Harkins Funeral Home, Inc., Delta, | | | | | | | | | | | | | |
| | | | Paint I chief the | disease, or contract failure. List only | plicetions thet caused one cause on each li | the death. Done. | o not enter t | he mode of dyir | ng, such as cardia | c or respiratory a | rrest, | | Approximete | tween | | |
| | Physician /Medical | | immediate Cause (F | inal | Λ | 11. | | G 10 () | 10.11 | :- | | İ | Onset and I | Deeth | | |
| | Examiner | Н | diseese or condition resulting in deeth) | | a. ———————————————————————————————————— | | - | | 111 | 1777512 | | | TEX | 175 | | |
| | | Jer | | | | Dua to (or es | a consequar | 1C8 OT): | | | | 1 | | | | |
| 1 | cate be axecuted physician and s the burial-transit | Examiner | Sequentially list conditions. Dua to (or as e consequenca of): | | | | | | | | | + | | - | | |
| 20, | oe axe cian a vurial- | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | | | | | | |
| 68760, | icate be axecuted physician and s the burial-transit | edicai | C. Due to (or es a consequenca of): Due to (or es a consequenca of): | | | | | | | | | İ | | | | |
| Box | attending for use as | | | | d | | | | | | | | | | | |
| m. | death certif e attending od for use a | icia | Pert II. Other elanific | cant conditions | contributing to death b | ut not resulting | in the unde | dvina cause aix | ren in Part I | 23h Did | tobacco use co | ntribute to | the cause / | of death? | | |
| o. | by the | Physician/M | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | at riot roouting | in the anda | nying occording | or we care to | | Y00 2 No | | ably 4 | | | |
| | | by | | | | | | | | | | | | | | |
| Ö | requires een sign hould be | eted | | | | | | | | | en autopsy ormed? | ave | ra autopsy f elleble prior t applation of c | to | | |
| of Vital Records, | has has | Completed | | | | | | | | | , | | death? | MUSE | | |
| a | t see | | OF Management | and the same office t | | | | | | 10 | | 1 | Yes 2 | No | | |
| 5 | | To Be | 25. Wes case raferre exeminer? | | Hospital: 1 ☐ Inpatie | a | Outpatient | 3□ DOA Oth | or: A | eth (Check only | | ar (Casaih | .) | | | |
| | g Phys er this seral d | | 27. Manner of Deeth | | 28e. Dete of Inju | ry 28b | . Time of | 28c. Injur | | dome 5 Resi | how injury occur | | ′/ | | | |
| 0 | Attending F r death. ector: After by the funer | atio | 1 Natural 2 Accident | 5 Pending investigatio | | y rear) | Injury | | Yes 2 □ No | | | | | | | |
| | or Attend after death Director: / d in by the i | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be datarmined | | ury - At home, c. (Specify) | ferm, street, | fectory, office | | 28f. Location (City or To | Street end Numb wn, Stata) | er or Rura | Route Num | nber, | | |
| | pital c | | 20a Cartilla | · · · · · · | wateles T. W. | | | | | | | | | | | |
| | To the Hespital or Attending Ph within 24 hours after death. To the Funeral Director. After th completaly filled in by the funeral | edicai | 29e. Cartifiar (Check only 2 one) | Certifying Pt Medical Exar | nyalclan: To the bast of niner: On the basis of end menner ste | exeminetion e | ge, deeth oc and/or invest | curred et tha tir igation, in my o | na, data and place pinion, deeth occi | e, and dua to tha urred et the time, | dete end plece, | annar es st and due to | ated. the ceuse(s | s) | | |
| | within To the compl | Me | 29b. Signature end ti | itle of certifier | | | _ | 29c. Licens | e number | | 29d. Date signe | d (Month, i | Dey, Year) | | | |
| | | | Der | 2 5 | Sela mos | , | | ME | 25210 | | JAN./28/2000 | | | 000 | | |
| | 3 | | 30. Neme and addras | | complated cause of d | eath (Item 23a | | | | | J.1 | 1- | - / - | | | |
| | | | JEM 31 DOLLER | 1 | Stims, my | | 116018 | city | mp, 2 | 1043 | | | | - | | |
| | Sta | 26 | 31. Deta filed (Month | ·, vay, real/ | 10 22 Hegistro | er's Signetura | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15=34 HMJ Russell Odin Kittelson 9 2000 JAN /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not Institution, give street end number) Examiner if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HARFOND RO AD IOCTA 1032 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) **Funeral** Months Days 130 M 2 F Yrs. 69 Apr. 1, 1930 Wisconsin **Director** 396-26-8375 Usual Residenca of Decedent 10d. inside City Limits 10a State 10b. County 10c. City, Town or Location r 28a-f show 1 Yes 2 No Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 21085 USA 1032 Joppa Road Peges 1 and 2 should be filed within 72 hours after death vest of Health and Mental Hygiene. The file of 7 is marked other than "natural", or items 23 mil. If item 27 is marked other than "natural", or items 23 mil. or other traumatic avent, the Medical Examine mail. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritel Status Black, Whita, etc. 157 Yes 2 No If Yes, Give Yeer or Dates: 1947–50 1 Never Merried 20 Merried 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Freight Carrier Truck Driver 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) Theodore Odin Kittelson Caroline (nmm) Geofert 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1032 Joppa Road, Joppa, Maryland 21085 Laura Gay Kittelson, Wife 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition important: If it any injury or o once. 1 □ Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Harford Memorial Gardens 1-22-00 Aldino, Maryland 21. Signetime of Funeral Service Licensee 22. Neme end Address of Facility McComas Funeral Home, P.A. 60 1317 Cokesbury Road, Abingdon, MD 21009 23a. Pert1. Enter the disease, or complication and paused the deeth. Do not enter the mode of dying, such as cardled or respiratory errest, shock, or heart feiture. List only one card on each line. Approximate Interval Between Onset end Death **Physician** /Medicai immediete Ceuse (Final diseese or condition resulting In deeth) A SCVD Examiner Due to (or es a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): 50 attending properties of signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown DIABESES MERLITUS þ 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Wes en eutopsy performed? Completed REMAL FAILURE is certificate hes director, page 2 1 Yes 2 No 1 Yes 2 KNo 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitai: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Aleturei 1 ☐ Yes 2 ☐ No 2 Accident rector: / 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of fnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 5 To the Hospital or within 24 hours eft To the Funeral Di completely filled in 29a, Certifier 1 Certifying Phyefofan: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and menner as stated Medicai Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner stated. (Check only one)

14

Hospital or Attending Physician:

death.

Direc

this

with the Maryland

altimore, Maryland 21215-0020

the death certificate be executed

Division of Vital Records, P.O.

State Registrar

Fulfred NABITY MID AVE 31. Dete filed (Month, Dey, Year) JAN 2 1 2000

Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signature end title of certifier

32 Registrar's Signeture Dener

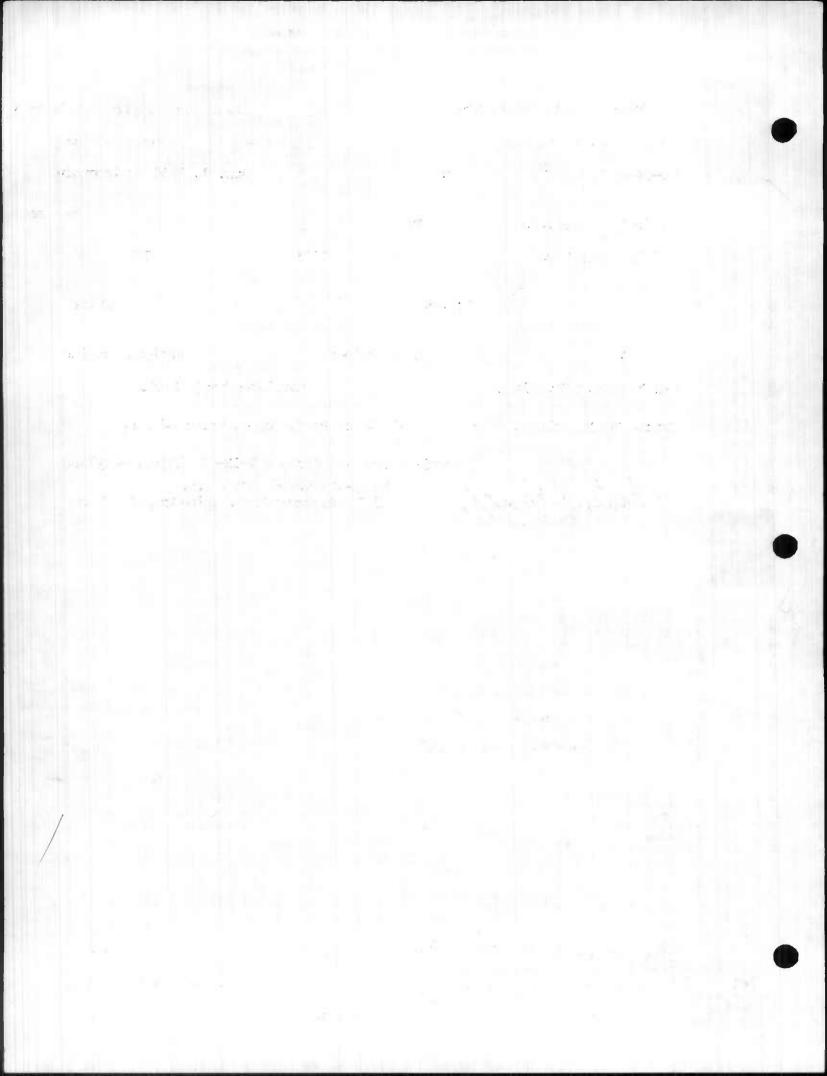
DM6

SELAIN MO 21014 410-879-6564

29c. License number

DUME

29d. Date signed (Month, Day, Year)

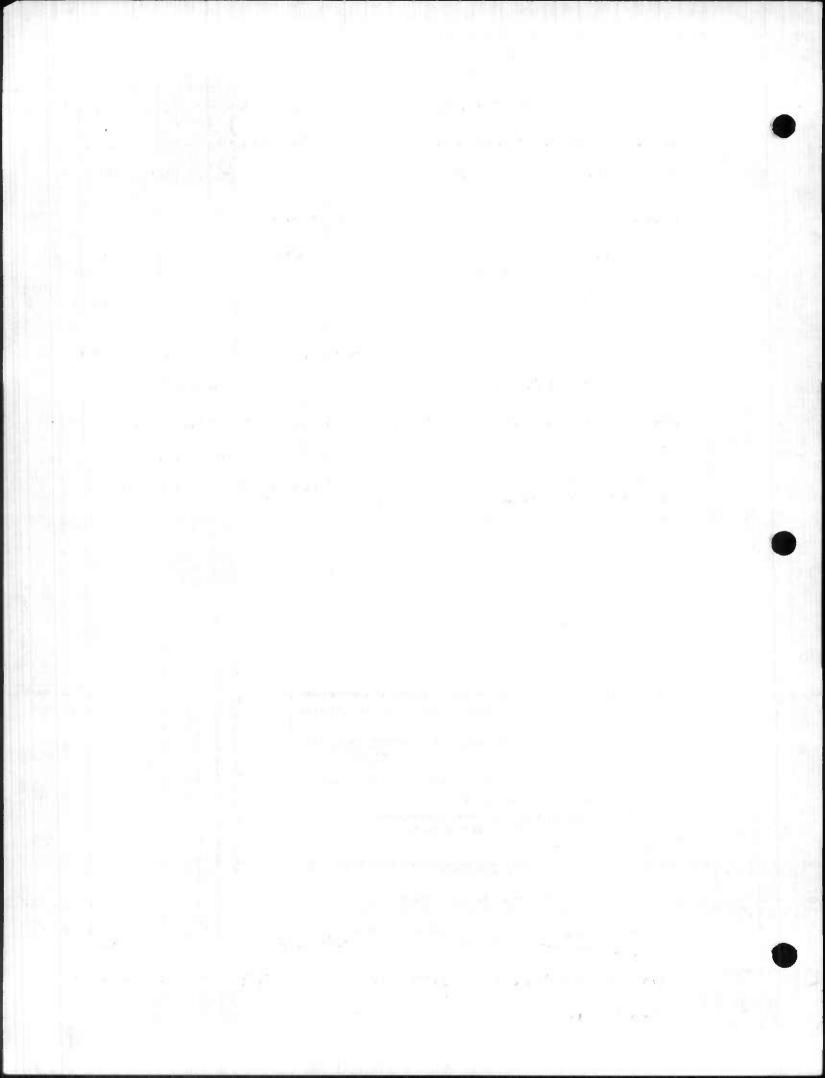


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 | 6

Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** 2, 2000 Dorothy DiGiovanni Krauss February 7:40 am /Medical 4e. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Residence: 914 Craigtown Road Port Deposit 5. Sociel Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jan. 31,1926 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Months Deys Hours Yrs. Director 220-12-7516 74 Maryland Usual Rasidance of Decedant death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yaa 🏋 No Director Port Deposit Maryland Cecil 10a, Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 Herns 23a 914 Craigtown Road 21904 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian Biack, Whita, atc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or If Yas, Giva Yeer or Datas: 1 ☐ Yas 2 ☒ No Specify: Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event and English and Page 1. Elemantary/Secondary (0-12) Eleven Years College (1-4or 5+) Homemaker Personal Residence 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Rocco DiMarco Mary Rapposelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Norman Krauss (Husband) 914 Craigtown Road, Port Deposit, Maryland 21904 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata XXBurlei 2 Cramation 3 Ramovei from State Mt. Erin Cemetery 2/5/00 Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Service Licenses 22. Nama and Addrass of Facility Lee A. Patterson & Son Funeral Home tellerox, S. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final Metastatic Soft Tissue Sarcoma amo. disaasa or condition rasulting in death) **Examiner** Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, laading to immediata cause. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 98 attending | P.O. 1 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by should b 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy cata has i 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificata Division of Vital Hospital or Attending Physician: '24 hours after death.' Funeral Director: Atter this certifica italy filled in by the funeral director, g 25. Was case rafarred to medical 28. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturai 5 Pending Invastigation 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital c within 24 hours at To the Funeral E completely filled 1 Cartifying Physicien: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as atated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar steted. 29a. Certifia: and titia of certifiar 29b. Signature 29d. Data signed (Month, Day, Year) 29c. License number D45390 2/3/2000 M-D. 30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print)

MYO MIN (Ih. D) 68-30 HOSPITAL DR #206, BALTIMORE, MD 21237 12 31. Data filed (Month, Day, Year) 32. Registrar's Signature State oods FEB 0 4 2000 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elsie Kellv 28. Jan. 2000 2:47 PM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Days 1□M 2K F Hours Months 579-44-7786 Yrs. 91 Director Washington, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahose Maryland Charles Waldorf 1 ☐ Yes 2 ☑ No Director 288-1 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerva 23a or 4006 Brewster Lane 20601 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status hours after 1 ☐ Never Married 2 ☐ Merried Specify:White b Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: 3XDWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry General Accounting Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Legal Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be fits Department of Health and Merital Hy Important: If Nem 27 is marked oth any Injury or other traumatic event 89 2 Clarence Hill Elsie Lowe 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph G.Kelly/Son 4006 Brewster Ln., Waldorf, MD 20601 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) Cedar Hill Cemetery 2/2/2000 Suitland, Maryland 21. Signature of Funeral Service-Licens 22. Name end Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 alas 23a. Pert1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert teilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** ARTERIOSCLEROTIC CANDIOVASCULAN /Medical Immediata Cause (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or Injury that initiated events resulting In deeth) Last Due to (or es a consequence of): Box 68760. physician Physician/Medical eug a Due to (or es a consequence of): P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 20KNo 3 Probably 4 Unknown Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 ☐ Yes 2 I No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of After 1 Neturel 5 Pending 1 Yes 2 No death. Investigation 2 Accident 24 hours after deat Funeral Director: Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier edical completely (Check only one) within 2. To the F ag g 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year) FEB 0 1 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) OLD LINE CENTER WALDONF, Md. ZEGOZ 32. Registrer's Signeture

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Piease Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\Omega\) \(\Omega\) \(\Gamma\) \(\Gamma\)

| | | | Cei | rtificate of | Death | | g. No. | 03103 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------|
| Physician | 1. Decedent's Nama (First, Middla, L Berta | Kluge | r | | | 2. Data of Death January | | 3. Time of Death 6:15pm |
| /Medical Examiner | 4a Facility Name (If not institution, go | va street and number) | | | 4b. City, Town, or | Location of Death | 4c. County of D | Deeth |
| SL. | Suburban Hosp | | | If Under 1 Yea | Betheson If Under 24 Hrs | | | gomery |
| Funeral Birector | | Sex 7. Age (In 10 M 2/1/15 9 | yrs. last birthday) 1 Yrs. | Months Day | | | Year 908 | Birthplace (State or Foreign Country) Austria |
| yland | 10a. State 10b. County | 100 | . City, Town or Lo | cation | | | | 10d. Inside City Limits |
| Be-fa | Maryland Mont | gomery | Rockvi | | | | | Mayos 2□No |
| of ther death with the Mar in thems 23e or 28ed a river must be notified Funeral Director | 10e. Street and Number 1801 Jefferso | n St Apt 5 | | 10f. Zip Code 2 0 8 5 | 2 | U | nited | |
| Ind 21215-0020 be filed within 72 hours after death with the Maryland hall Hyglene. d other than "natural", or thems 23e or 28e4 show avant, the Medical Exemines must be notified. Be Completed by Funeral Director. | 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yas, Giva Yaar or Datas: | | Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ N | Hispanic Origin? (S ban, Mexican, Puer o Specify: | Specify Yes or No- to Rican, etc.) | Specify: | Vinite, etc. White etc. |
| 72 h | 15. Decedent's E (Specify only highest g | ducation ade completed) | 16a. Dece (Give | dent's Usuel Occi kind of work don | upation e during most of wo red) | rking | 6b. Kind of Busine | ess/Industry |
| 1 21215-00 ed within 72 hot yglene. Writhen "neture it, ir westered | Elementary/Secondary (0-12) | College (1-4or 5+) | Furi | | rea) | | Retail (| Clothing |
| | 17. Fathar's Name (First, Middle, Las | | | | 18. Mother's Na Mati | me (First, Middle, M | laiden Sumama) Unknowi | n" |
| re, Maryla s 1 and 2 should l Health and Men tem 27 is marke other traumatic | 19a. Informant's Neme/Relationship Marlene Beckma | (Type, Print) in/Daughter | 19b. Meilin 6 4 1 2 | ng Address (Stree 79th | et and Number or R St Ca | ural Route Number, bin John | City or Town, Sta | te, Zip Code) 0 8 1 8 |
| Baltimore, N permit. Pages 1 and Department of Health Important: if New 27 any injury or other tr ance. | 20a. Method of Disposition 1 🖾 Burlal 2 🗆 Cramation 3 4 🗆 Donation 5 🗀 Other (Spec | Removal from State | b. Place of Dispo cematery, cree C Lodge | matory or other pi | | 2/2/200 | 00c. Location - City 00 Was1 | or Town, State |
| Baltimor permit. Pages Department of H Important: If the any injury or of page. | 21. Signeture of Furrigial Service Lice | nsee de la la la la la la la la la la la la la | _ | | | | | morial F.H. , DC 20012 |
| 5 - 1 | 23a. Pert1. Enter the disease, or cor shock, or beart failure. List only | iplications that caused the cone cause on each line. | eath. Do not ent | er the mode of d | ying, such as cardia | c or respiretory arre | st, | Approximate Interval Between |
| Physician /Medical Examiner | Immediata Causa (Final diseasa or condition resulting in death) | a METASTA | Tic po | -21-11 | atic C | ancer | | 2 weeks |
| Box 68760, seth certificate be assecuted attending physician and for use as the burla-transit clan/Medical Examine | Ceusa (Disease or Injury that initiated events resulting in death) Last | С. | o (or as a conseq | | | | | |
| death death od for a | Part II. Other algnificant conditions | contributing to death but not | rasulting in the u | nderlying causa (| given in Part I. | 23b. Did to | bacco una contrit | bute to the cause of death? |
| Ords, P.O. Box requires that the death cent even signed by the attending hould be detached for use eted by Physician/M | | | | | | 1 🗆 Ye | 8 2 X No 3[| Probably 4 Unknown |
| () _ 0 0 | | | | | | 24a. Was ar perform | | 4b. Wara autopsy findings available prior to completion of cause of death? |
| The law ate has page 2 | | | | | | 1□ Ye | s 2 X No | 1 ☐ Yes 2 ☐ No |
| Of VItal I Physician: The this certificate rel director, pag. To Be Co | 25. Was case referred to medical axaminer? | Hospital: | | 10 | Whor | ath (Check only one | | |
| | | 28a. Dete of Injury (Month, Day Yea | 2 ER/Outpatier 28b. Time o | N 3LI DOA | 4 U Nursing I | Home 5 Reside | | Specify) |
| DIVISION To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After t completely filled in by the funer Medical Certification: | 1 Netural 5 Pending 2 Accident invastigeti 3 Suicide 8 Could not 4 Homicide determine | on Die Stere of Injury | At home, farm, str | M 1[| ☐ Yes 2 ☐ No | 28f. Location (Str City or Town | eet and Number o | or Rural Route Number, |
| he Hospital in 24 hours a he Funeral I pletely filled | 29a. Certifier 12 Certifying P (Check only one) 2 Madical Exa | hysician: To the best of my miner: On the basis of exan and manner stated. | knowledge, deatl nination and/or in | n occurred at the vestigation, in my | time, dete and place opinion, deeth occ | e, and due to the ca urred at the time, de | use(s) and manne ite and place, and | er as stated. due to tha cause(s) |
| within 2 To the comple | 29b. Signatura and titla of certifier | | | 29c. Lice | nse number | 29 | d. Data signed (A | fonth, Day, Year) |
| | 1 June | 2 Suffer | Cen- | D4 | 3083 | | Feb. | 1, 2000 |
| (10) | 30. Name and address of person who George Sold | 39 9707 | Medic | Print) | | #300 R | | MD 20850 |
| State Registrar | 31. Date filed (Manth, Day, Year) FEB 0 4 2000 | 32. Registrar's S | ignature | boards | 7 | | | |

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Month MARGARET PATRICIA KNOWLES 02/ 02/ 2000 8:10_AM 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Prince Georges Mitchellville 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 M 2 F 89 Vrs 577-07-1156 Oct.21,1910 Washington, DC Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Ft. Washington 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2204 Tonga Dr. 20744 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3℃Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 8th Bookkeeper Accounting 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Hubert F. McConnell Margaret Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Margaret P. Tait/Daughter same as item 10 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 2/5/2000 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Ow ann or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finai disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequenca of): Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturai 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide

The law requires that the death certificate be execu P.O. Box 68760. Records, Division of Vital Hospital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

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s marked other than "natural"

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Baltimore, Maryland 21215-0020

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

State Registrar

31. Date filed (Month, Day, Year) FEB 0 4 2000

Neme end address of person who

cortifie

32 Begistrar's Signature

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) in the place and place.

29c. License number

populi, col, Comba us 70716

29d. Dete signed (Month, Day, Year)

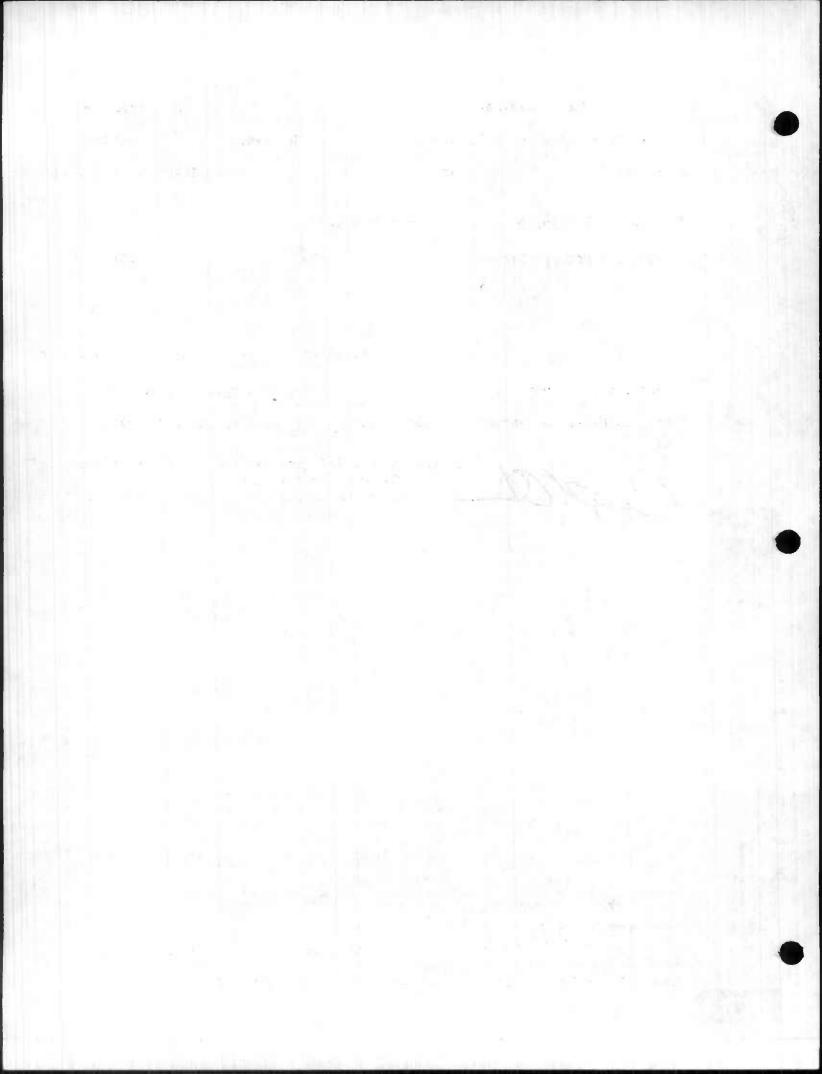
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 5 1 6 5

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Pauline Pearl Kaetzel Jan. 31 2000 6:15 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Dey, Yeer) Jan. 4, 1915 **Funerai** 1 M 2 X F Days Maryland 214-09-6586 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show the Medical Examiner must be notified at the Maryla 1 Yes 2 TANO Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? flerns 23a or Funeral 21795 235 East Potomac Street USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married b altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced "natural" White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembler Aircraft Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 2 should be to and Mental F is marked of 8 2 Pages 1 and 2 should Jerry Elias Young Sophia Virginia Howelette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health important: if Item 27 i Cheryl L. Miller-Daughter 235 E. Potomac St. Williamsport, MD 20a. Method of Disposition

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Placa of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State ö 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Memorial Park 2-3-00 Williamsport, Maryland 21. Signature of Funeral Service Licenses USBOTHE THE THE HOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 or the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Physician Butin Immediate Cause (Final 5 vdJen disease or condition resulting in death) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical Due to (or as a consequence of) for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 □ Probably 4 □ Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2: 2 X No certificate 1 ☐ Yes 2 ☐ No lal or Attending Physician: The state death.

It Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how Injury occurred Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0011266 Jan. 31,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard N. Weeks, MD 580 Northern Ave. Hagerstown, MD 21742 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State FEB 0 1 2000 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 05 166

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| . Sex V 7. Ag | | | | | | | ition of Death | 4c. County | | |
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| 1□M 2ÅF | 40 (in yrs. ii | est birthday, Yrs. | Months | | | Min. | Month, Day, ec. 15, | 1959 | Pennsy | ce (State of F y) Volvania |
| | 10c. City | , Town or L | ocation | | | | | | 100 | d. Inside City I |
| rundel | | į | Riva | | | | | | | 1 □ Yes 2 |
| Tunder | | | | p Code | | | 10 | g. Citizen of 1 | What Countr | y? |
| e Way | | | 2 | 1140 | | | | USA | | |
| Armed Forces? 1 Yes 2 N | 7 | 5. 13. | If Yes, spe | ecify Cub | an, Mexican, | in? (Speci Puerto Ri | ify Yes or No- can, etc.) | Blad | ck, White, et | c. |
| Education | | | | | | | 1 | 6b. Kind of B | usiness/Indu | stry |
| | 54) | (Give | DO NOT | ork done use retire | during most d) | of working | | | | |
| 4 vrs. | 34) | Occup | patio | na1 | Health | Nur | se | Med: | ical | |
| | | | | | | | | laiden Surnan | 10) | |
| . Kelly | | | | | Gert | rude | Dorsey | | | |
| (Type, Print) | | 19b. Meili | ing Addres | s (Street | t and Number | r or Rural i | Route Number, | City or Town, | State, Zip C | Code) |
| Jr./Husband | d | 3283 | Brec | kenr | idge W | lay R: | iva. Ma | ryland | 21140 |) |
| DRamous from State | 20b. Pla | ace of Disponentery, cre | osition (Na matory or | other pla | ce) | | Data 2 | Oc. Location | City or Tow | n, Stata |
| | | | | | | 1-2 | 26-00 C | onshoh | ocken, | PA |
| ensee | | 2 | 2. Name a | nd Addre | ess of Facility | / | | | | |
| 10- | | Ge | eorge | Ρ. | Kalas | Funer | ral Hom | е | MD | 01007 |
| molications that cause | d the death | Do not en | 1/3 S | OTOW | ons Is | STand | Kd. Ed | gewate: | | 21U3/_ |
| b | | | quence of |): | | | | | 1 | |
| с | | | | | | | | | | |
| ■ d | Due to (or | as a consen | querica or) | | | | | | | 1/2 |
| | | | | | | | | | 1 | |
| contributing to death b | out not resu | iting in the i | underlying | cause gr | ven in Part I. | | | 11 | | |
| | | | | | | | 10 14 | 18 ST/140 | 3 Prode | ibly 4 0 |
| | | | | | | _ | 24a. Was ar perform | autopsy ned? | avai | e autopsy find lable prior to pletion of cau sath? |
| | | | | | | | 1□ Ye | s 210-No | 10 | Yes 2□ No |
| 1 | | | | | 26. Place | of Death (| Check only one | 9) | 1 | |
| Hospitel: 12 Inpetie | ent 2 E | ER/Outpatie | nt 3 D | OA OI | her | | | | er (Specify) | |
| 28a. Date of Inju | Jry : | 28b. Time o | | | | 7 | | | | |
| | ly rear) | injury | М | | | No | | | | |
| d 289. Place of in | | | reet, facto | ry, office | | 28 | of. Location (Str City or Town | reet and Numi , State) | per or Rural | Route Numbe |
| aminer: On the basis of | f examination | | | | | | | | | |
| 1/1/1 | | | 29 | c. Licens | se number | / | 29 | d. Date signe | d (Month, D | ay, Year) |
| 1) Willin | Nm | | | 20 | 811: | 8 | | 1/ | | 1100 |
| o completed cause of o | leath (Item | 23a) (Type | Print) | Sta | nley P | Wat | tkins, | M D | | |
| | A COLO | (. lho | | | | | | | | |
| TE NO | 24 | NAVI | 2001 | 15 | M | 0 | 274 | 0/ | | |
| | Armed Forces' 1 | 12. Was Decedent Ever in U.s Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates: | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates: 16a. Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates: 16a. Decedent Grade completed) 16a. Decedent Grade Completed 16b. 16b. Meil 3283 20b. Place of Disposemetery, crecedent Grade Completed Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposemetery, crecedent Grade Completed Inc. 20b. Place of Disposement Grade Completed Inc. 20b. Pla | 2 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No I Yes, specified of Wyes, give Year or Dates: 16a. Decedent's Using Give kind of willie. Do Not of College (1-4or 5+) 4 yrs. 0ccupation 16b. Decedent's Using Give kind of willie. Do Not of Calvary. Compation 19b. Meiling Address 3283 Brecometery, crematory or Calvary Cemeters 22. Name and George 2973 S. 29 | 12 Was Decedent Ever in U.S. Armed Forces? 1 | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Give 1 Yes 2 No Nevicen 1 Yes, Give Year or Dates: 1 Yes 2 No Specify: Yes, Sind of work done during most life. Do NOT use retired Yes. Nother College (1-4or 5+) 4 Yes. 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 g/No Yes 2 g/No 1. Yes 2 g/No 1. Yes 2 g/No 1. Yes 2 g/No 1. Yes 2 g/No Yes 2 g/No 1. Yes 2 g/No 12 Was Depocted Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mercian, Puerfo Rican, etc.) 1 | 2 Way 21140 USA | Re Way 21140 USA |

JAN 8 7 2000 P 3 MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 6 7

| | | | | Cei | rtificate of | Death | F | leg. No. | | | |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------|-------------------------------|---------------------------|-------------------------------------------------------------|---------|
| | | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of Dea | ith | Vac | 3. Time of D | eath |
| | Physician | Jacque | line Olivia | Krauss | | | January | 23, 200 | Year | 8:30 | A.M. |
| | /Medical Examiner | 4a Facility Name (If not Institution, give | | | | 4b. City, Town, or I | | <u> </u> | | | |
| | Examiner | Genesis Elderca | | pa Creek | | Anna | apolis | Anne | Arund | e1 | |
| - | 5 | 5. Social Security Number 6. S | | n yrs. last birthday) | If Under 1 Year | | • | | 9 Birthola | ce (State or | Foreign |
| | Funeral Director | 577-18-1214 | IDM 30√F 86 | Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day Sept. 8 | ,1913 | South | Carol | ina |
| | P | Usual Residence of Decedent 10a. State 10b. County | 10 | c. City, Town or Lo | ocation | | | | 100 | d. Inside City | Limits |
| | or 28a-f sho be notified a | | Carteret | Beauf | | | | | | 1 ☐ Yes 2 | XXV0 |
| | | 10e. Street and Number 520 Glory Road | | | | 3156 | | 10g. Citizen of W | A | | |
| 020 | ar, or its Examine by Fur | 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | Was Decedent of H ff Yes, specify Cubo 1 ☐ Yes ŽŽ No | dispante Origin? (S) an, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | 14. Race Blace Specify. | - America k, White, et | ic. | |
| 5-0 | 72 h | 15. Decedent's E (Specify only highest gre | ducation ade completed) | 16a. Dece | dent's Usual Occup | etlon during most of wor | kina | 16b. Kind of Bu | siness/Indu | stry | |
| Maryland 21215-0020 | ed within 72 ho yglene. wer than "natum it, the Medical. Completed | Elementery/Secondary (0-12) | College (1-4or 5+) | | kind of work done DO NOT use retired ecretary | d) | | Bai | nking | | |
| 9 | | 17. Father's Name (First, Middle, Last |) | | oci coar j | 18. Mother's Nen | ne (First, Middle, | | | | |
| a | Mental H Mental H rkad ott fic ever | John Alexand | | | | | Eleanor | | | | |
| 7 | 32 2 2 P | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Mailie | ng Address (Street | end Number or Ru | ral Route Numbe | r. City or Town. | Stete, Zip C | Code) | |
| | and 2 sh eaith and m 27 is m | Carolyn E. Payne | | | Glory Roa | | | | | | |
| ē, | -115 | 20a. Method of Disposition | Daughter 2 | Oh Place of Dispo | sition (Neme of metory or other plea | | Date | 20c. Location - | City or Tow | m, State | |
| Baltimore, | thent if la | 1 Burial 2 Cremation 3 4 Donation 5 Other (Special | (y) | Ft. Lince | oln Cemet | ery | 1-25-00 | Brentwo | od, Ma | arylan | d |
| Bal | Departiment of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the parties of the pa | 21. Signatury of Funeral Service Licer | 1988 | Ge 29 | 2. Name and Address eorge P. 973 Solom | Kalas Fu Ions Isla | neral Ho | me dgewate | r, MD | 21037 | |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the | death. Do not ent | ter the mode of dyir | ng, such as cardiac | or respiretory ar | rest, | | Approximate Interval Betwe | |
| | Physician | | | 0.1 | | | | | (| Onset and De | eath |
| | /Medical Examiner | Immediate Cause (Final disease or condition | | 111 | mora | emb | ولسأنا | | | 11/4 | |
| | | resulting in death) | Due | e to (or as a consec | quence of): | | | | | 1 | |
| | N E | | h | | | | | | 1 | | |
| o, | certificate be executed of ording physician and use as the burial-transit or Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | Due | to (or as a consec | quence of): | | | | | | 16 |
| 68760, | ficate be physicians the bu | that initiated events resulting In death) Last | C. Due | to (or as a conseq | juence of): | | | | | | |
| Вох | nding use a | | d | | | | | | | | 0 |
| m | # # P P | Part If. Other algnificant conditions of | contributing to death but as | nt reculting in the u | ndorbina cauco ak | ren in Part f | 23h Did t | obacco use cor | tribute to | the cause of | death? |
| 0 | £ 5 > | Part II. Other significant conditions of | ontributing to death but no | of teanistid in the n | noerlying cause giv | veri mi ranti. | 101 | - | 3 Probe | | Inknown |
| 0. | 5 60 | Deventu | | | | | | | | , | |
| Records, | been s should should | | | | | | | an autopsy med? | com | re autopsy fin lable prior to apletion of ca eath? | |
| I Re | The law ate has be page 2 s | | | | | | 101 | es 2/2190 | | Yes 2 N | No |
| Vital | certificate irector, pag | 25. Was case referred to medical examiner? | | | | 26. Place of Dea | ith (Check only o | ne) | | | |
| > | 0.0 | 1 Yes 27 No | Hospital: 1 ☐ Inpatient | 2 ER/Outpatier | nt 3 DOA Oth | ner: Nursing H | ome 5 Resid | ience 8 🗆 Oth | er (Specify) |) | |
| on of | Attending Phire death. octor: After this by the funeral fill cation: 1 | 27. Menner of Death 1 Netural 5 Pending 2 Accident investigatio | 28a. Date of Injury (Month, Dey Ye | 28b. Time of fnjury | Wor | y at rk? Yes 2 □ No | 28d. Describe h | ow injury occurr | ed | | -21 |
| Division | late or Attending P rs after death. at Director: After t led in by the funer: Certification: | 3 Sulcide 6 Could not be determined | | At home, farm, str Specify) | reet, factory, office | | 281. Location (S City or Tow | itreet and Numb n, State) | er or Rural | Route Numb | 107, |
| | Hospi 4 hour Funer tely fill | | ystclan: To the best of my niner: On the basis of exa and manner stated | aminetion and/or in | | | | | | | |
| | within 2 To the comple | 29b. Signature and title or pertilier | | | 29c. Licens | e number | | 29d. Date signed | d (Month, D | Pay, Year) | |
| | - 5 F Ö | > 7) (X) | Eu, | | 1) | 8203 | 5 | January | 24 | 2000 | |
| | | 30. Nama and address of person who | completed cause of death | (Item 23a) (Type | | 3 3 3 4 | ~ | oanual y | ~~· , . | 2000 | |
| | | Gan J. | Sprane | 2/02 | Didor | echo Pr | we a | Leiter. | mo. | 2/6/ | 19 |
| | State | 31. Date filed (Month, Dey, Year) | 32. Registrar's | Signature | | | | | | | |
| | Registrar | MM 2 7 200 | In December | ~ A | 1 | 1 , | | | | | |

M 27 2000 James D. Arrest

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Mary Sue Kushner 20, 2000 January 10:35PM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Prince George's Hospital Cheverly Prince George's If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) NOV. 13, 1 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiace (Stata or Foraign Country) 1□ M 2 F Months Days Hours 227-44-2979 65 Yrs. 1934 Kentucky Usuai Rasidance of Dacedan 10a Stata 10b. County 10c. City. Town or Location 10d. insida City Limits 1 Yas 2 No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8009 Carmel Drive 20747 U.S.A. 12. Was Dacedant Evar In U.S. Armed Forcas? 1 Aras 2 No 1952-1 Yas, Give Yaar or Datas: 1955 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Maritai Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation 15. Decedent's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada complated) Federal Government Etementary/Secondary (0-12) College (1-4or 5+) N/A Secretary Census Bureau 18 Mother's Name (First Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Mark V. Smith Marie Bowling 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. informent's Name/Retetionship (Type, Print) 8009 Carmel Drive Forestville, Maryland 20747
Disposition (Nama of Tan 21 2840 20c. Location - City of Town, Stata John J. Kushner (Husband) 20b. Place of Disposition (Nama of cematary, crematory or other place) Jan. 31,2000 20e. Mathod of Disposition Buriai 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington Virginia 21. Signature of Fort ral Service Licent 22. Nama and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 M01095 lical ons that coused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, one saw that coused the death. Approximate interval Between Onsat and Deeth 23a. Party Entar tha disaasa, or for short, or heart failura. List Immediate Cause (Final disaesa or condition resulting in deeth) Cardiac Arrest Dua to (or es a consequence of): Athrosclerotic Cornary Artery Disease Sequentially list conditions, if eny, laeding to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to comptation of cause 24e. Wes en autopsy performed? of death?

Physician /Medical Examiner

the death certificate be executed

peen

certificate

or Attending Physician: after death. Director: After this certifica funeral director.

within 2

page 2 s 788

5

filled in 24 hours hours a Hospital

completely

P.O. Box 68760

Division of Vital Records,

permit. Page Department of Important: If eny injury or

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

the Menyland or 28a-f ahow

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or items 23a or inty or other treumatic event, it Mental is a vice marked other treumatic event, it would is a vice marked.

Baltimore, Maryland 21215-0020

Examiner physician end s the burial-transit Physician/Medical 98 use signed by the e

by

Completed

8

Certification: To

Medical

1 Yas 2 No 26. Placa of Death (Check only ona)

N/A 1 Yas

25. Was case refarred to medical axaminar? 1 Yas 2 No 27. Mannar of Deeth 1 XNeturei 5 Panding

invastigetion

1 Inpatient **2**CXER/Outpetient 3□ DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Dascribe how injury occurred

6 Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

281. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one)

2 Accidant

3 Sulcida

4 Homicide

1 Xxertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

29b. Signatura and titla of certifian

Joseph

0 26056 usa of death (Nam 23a) (Type, Print) 3001 Hospital Drive Cheverly, Maryland 20785

1 Yas

2 No

January 22, 2000

State Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death 2. Deta of Deeth 2, 2000 1120 AM Karl Barnes Knust, Jr. Feb. 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Deeth Talbot Memorial Hospital @ Easton Easton, MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 5. Social Security Number Days MM 2□F Months Hours 218-28-4451 Yrs. 68 Sept. 4, 1931 Puerto Rico Usual Rasidence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits N Yas 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 Colonial Dr. 21629 U.S.A. 14. Race - Amarican Indian, 12. Was Decedent Ever in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 🖾 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 4 Technical Writer Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Karl Barnes Knust, Sr. Lucina Andrus 19a. Informent's Neme/Reletionship Sme_Tini-law & 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Arthur Flinner-Guardian 122 West Lanvale St., Baltimore, MD 21217 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stata 20e. Method of Disposition Date 1 ☐ Burial 2 XCrametion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cambridge Crematory 2-4-2000 Cambridge, MD 21. Slamula of Funerel Service Licenses 22. Neme and Address of Fecility Curran-Bromwell Funeral Home, P.A. There the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one dause of each line. Approximate Interval Between Onset and Death Immediate Causa (Finel disease or condition resulting in deeth) mon Due to (or as a consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence ot) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Winknown

Physician /Medical Examiner

burial-transit

the

980

and

physician

After t or Attending hours after death. Director:

in 24 hour.

within 2

the Hospital

Box 68760. certificate be

P.0.

Division of Vital Records.

Physician

/Medical

Examiner

10a State

Funeral

Director

notified at

b

or Herne 23a

7 is marked other than "natural", or itsn traumatic event, the Medical Examiner.

permit. Pages 1 and 2 should be fled within Department of Health and Mental Hygiene. Important: if health and marked other than "n any Injury or other traument.

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Examiner Physician/Medical by Completed Be 2 Certification:

27

29a. Certities

Medical

Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. sease

24e. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yas 2 No

| 25. Wes case raferred to medical | | | | 26. Place of Dec | eth (Check only one) |
|--------------------------------------------------------------------|----------------------------------------|---------------------|--------|----------------------------------|-----------------------------|
| axaminar? 1 ☐ Yes 2 ☐ No | Hospitel: | 2 ER/Outpatient | 3□ DOA | Other: 4 Nursing H | fome 5 Residence 8 □ |
| 27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation | 28a. Dete of Injury (Month, Day Yea | 28b. Time of Injury | 28c. | fnjury at Work? 1 Yes 2 No | 28d. Describe how injury of |

6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steled.

(Check only one) 29b. Signature and titla of certifian

29c. License number

29d. Date signed (Month, Dey, Year)

Other (Specify)

curred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

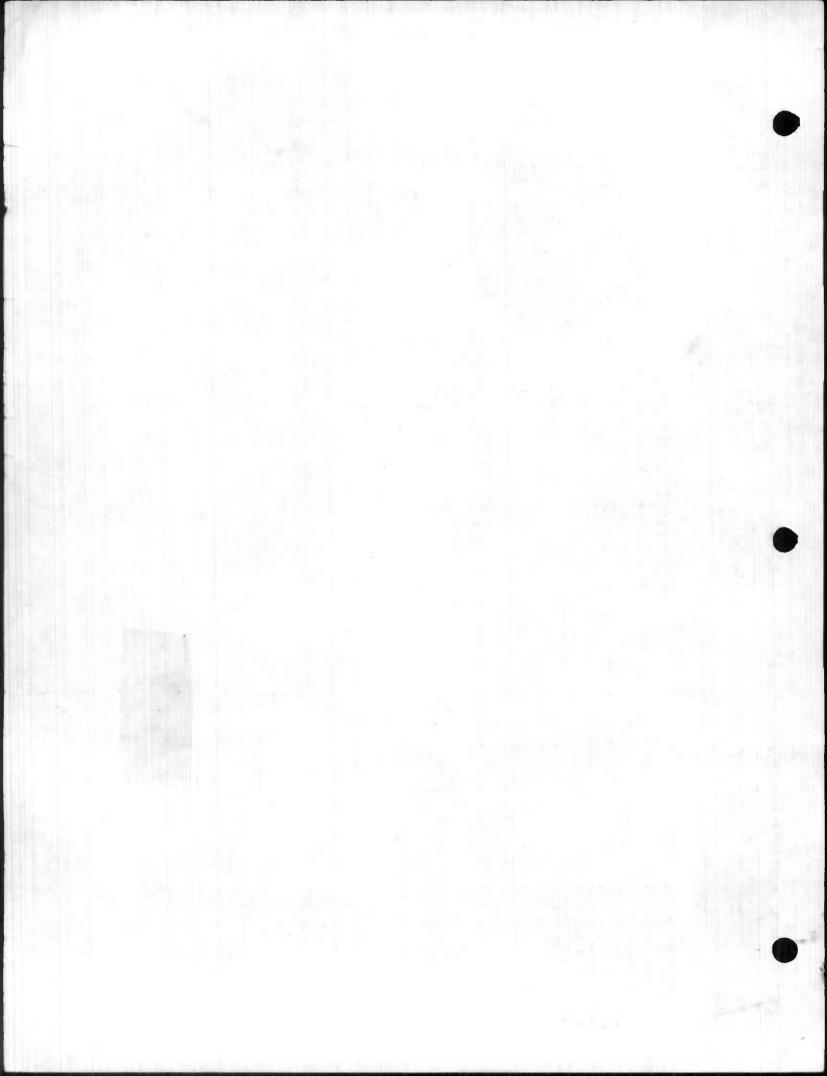
Moffet P.O. Box 660, Denton, MD 21629 K. 31. Data tiled (Month, Day, Year)

FEB 0 4 2000

32. Registrar's Signeture Dener

ooks

State Registrar



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 05170 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Clayton Aloysious LOWRY, Jr. January 31, 2000 18:25 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Southern MD Hospital Center Prince George's Clinton 8. Dete of Birth (Month, Dey, Year) Aug. 28, 1 If Under 1 Yeer If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Wash., DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min. Days Months Hours t M 2□ F 64 214 32 9887 1935 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Calvert Huntingtown 1 ☐ Yas 2 ☐ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1021 Lower Marlboro Road 20639 USA 13. Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11 Merital Stetus 14. Rece - American Indien. Bleck, White, etc. 1 ☐ Yes 2 € No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: white Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 painting contractor commercial painting 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Clayton Aloysious Lowry, Sr. Evelyn Gertrude Purdy 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Jane Lowry (wife) same as 10 above 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) 2-4-00 Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility 21. Signeture of Funeral Service Leanuer Rausch Funeral Home, Owings, MD 23a. Part1. Enter the disease, or complications that cadsed the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth PULMONARY EMBOLISM Immediate Ceuse (Finel 6 HOURS disease or condition resulting in death) Due to (or es a consequence of): Due to (or es a consequença of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEMIPLEGIA 24a. Was an autopsy parformed?

Physician /Medical Examiner

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After

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The law requires that the death certificate be executed

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Division of Vital Records,

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Baltimore, Maryland

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury fhet initiated events resulting in death) Last Completed by

CORUNARY ARTERY DISEASE Preumonia. Aspiration 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 200 No 1 Yas 2 No

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death 1 Netural 5 Pending

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Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, sfreef, fectory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

SURANA

29a. Certifier (Check only one) Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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CHAND

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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02-01-2000

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32. Registrer's Signeture

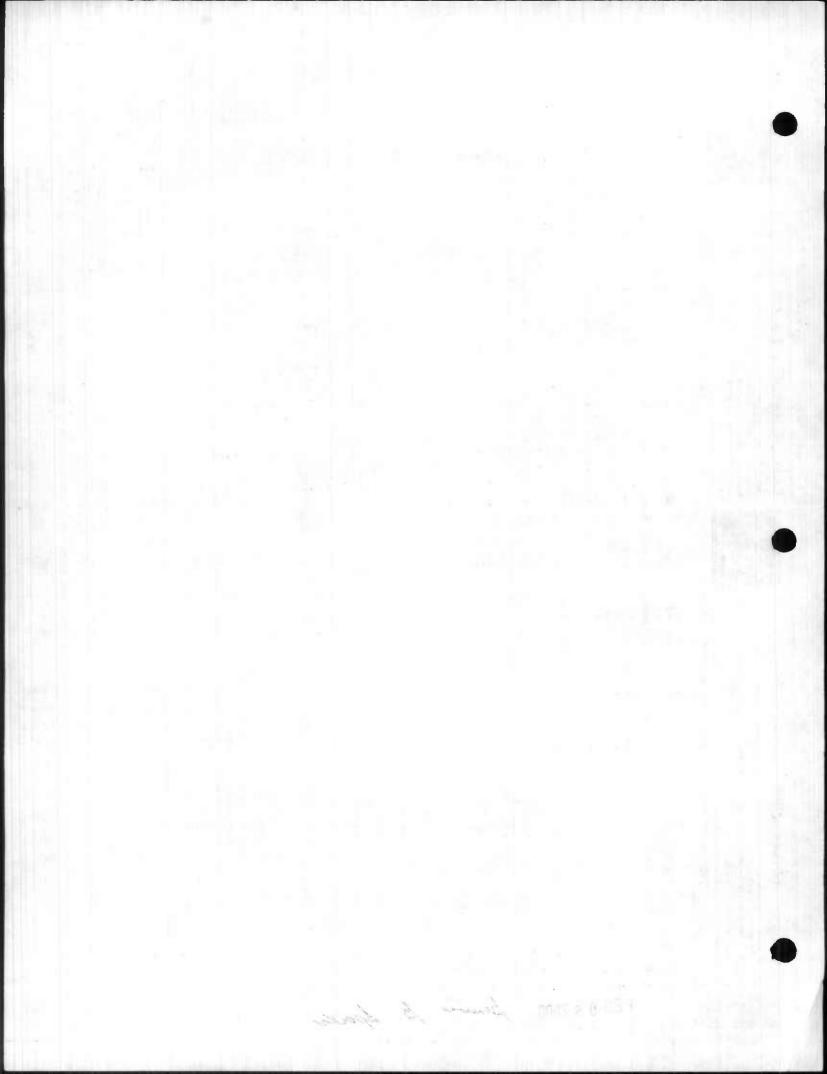
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State of Maryland / Department of Health and Mental Hygiene

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| 29 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 7 February 5, 2000 7 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Oath Filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Physicar's Signature | | 5 | | (Month, Day Ye | | ry | | | 28d. Describ | now injury occu | red | |
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| 29c. License number 29d. Date signed (Month, Day, Year) DH7158 February 5, 2000 20. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vach - Van Lin MD 2001 Medical Parkuray Anapolis, MD 24401 31. Date filled (Afonth, Day, Year) 32. Pagistrar's Signature | Pur Pur | | (Check only 2 Medical Exami | ner: On the basis of exa | y knowledge, d mination and/o | eath occurre r investigati | d at the tir | ma, data and place opinion, deeth oc | ce, and due to th curred at the time | a causa(s) and m | annar as s | itated. to the cause(s) |
| Name and address of person who completed cause of death (Item 23a) (Type, Print) Vach Van Lin, MD 2001 Medical Parkney Amapolis, MD 24401 State St. Date filed (Afonth, Day, Year) 32. Aggistrar's Signature | B chit | | | and mainter stated. | | | 9c. Licens | se number | | 29d. Date signs | ed (Month | Day Year) |
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| Registrati | | 400 | 3T. Date filed (More), Pay Year) 200 | | | | | | • | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2 20 pm Kanda Clair Lehman 2000 February 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Arundel Anne Arundel Medical Center Annabolis Anne If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days Hours 20 1⊠M 2□ F Months N/A February 2, 2000 Maryland Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d Inside City Limits 1 Ves 2 No Maryland St. Mary's Mechanicsville 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20659 USA 25925 Friendship School Road 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
if Yes, Give
Yeer or Detes: Black, White, etc. 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lynn Stauffer Clair Albert Lehman Tammy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 25925 Friendship School Rd, Mechanicsville, Maryland 20659 Clair A. Lehman (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State Mechanicsville Mennonite Ceme. 2/8/2000 | Mechanicsville, Maryland 4 Donetion 5 Other (Specify) 22. Name and Address of Facilit 21. Sign@ure of Funerel Service Lios Mattingley-Gardiner Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Distress Syndrome 20 hrs hours Syndrome Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 20 hours Prematurit c. Extreme Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

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the Medical Examiner must b

Hygiene.

permit. Pages 1 and 2 should be liled Department of Health and Mental Hygi Important: If them 27 is marked other any injury or other traumatic avent. It

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Directo

Funeral

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Completed

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physician and the burial-transit Physician/Medical signed by t p Completed Be 10 inspital or Attending Pt. vin 24 hours after death. Ye Funeral Director: After Privately filled in pure. Certification:

peeu

certificate

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Ves 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steled.

State Registrar

Medical

29b. Signeture end title of certifier

ann-Yann EB 0 8 2000

MAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lin, MD 2001 Medical Parkway, Annapolis, MD 2140 32. Registrer's Signeture

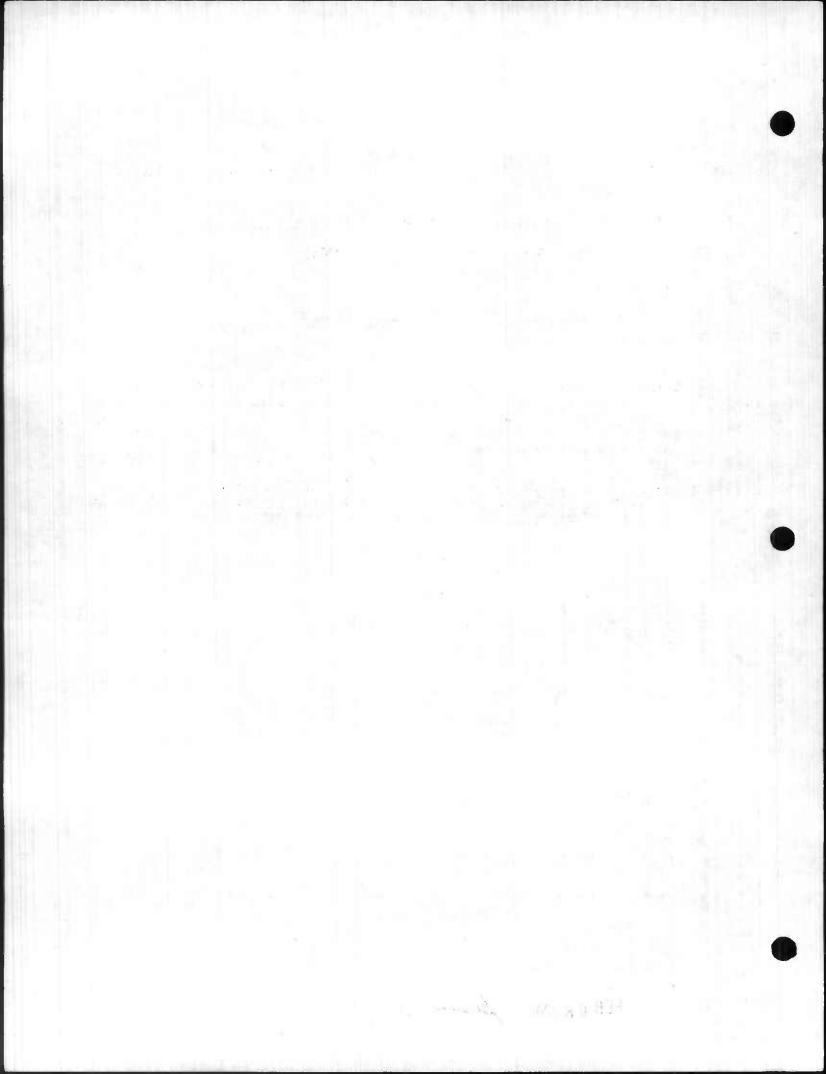
29c. License number

D47158

29d. Dete signed (Month, Day, Year)

04,2000

within 2 To the



State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Year Month **Physician** VOSEPH-0115 LITTLE 09=16 AM MAL 2000 20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hours Min. B. Dete of Birth (Month, Day, Year)
Jan. 18, 1925 GENERAL HOSP, TAL butus Falht 7. Age (In yrs. lest birthday) If Under 1 Year Months Deys 5. Social Security Number 6. Sak Birthplace (State or Foreign Country) **Funeral** Deys 75 213-20-5773 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Harford Directo 28a-f Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò na 23a or must be 1402-E Bonnett Place 21015 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after a ment of yealth and Methal Hyglens. ment if term 27 is mensed other than "natural", or lies any or other traumatic event, the Medical Laurifices 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: WW II 1 ☐ Never Married 2 ☑ Merried Specify: White Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Salesman Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Louis Little u/k u/k u/k Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rose Mary Little- wife 1402-E Bonnett Place, Bel Air, Maryland 21015 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from State permit. Page Department of Important: If any Injury or otice. Darlington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01/24/2000 Darlington, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A. itum of Funeral Service License se, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, . List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical ASCJD Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the buriei-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as e consequence of): Use as 1 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Allunknown ate has been signed page 2 should be de Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital Physiclan: Be 25. Was case referred to medical 28. Place of Deeth (Check only one) Hospitel: edical Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2□ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division or Attanding a after de. el Director: Afte 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funerel Completaly filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.

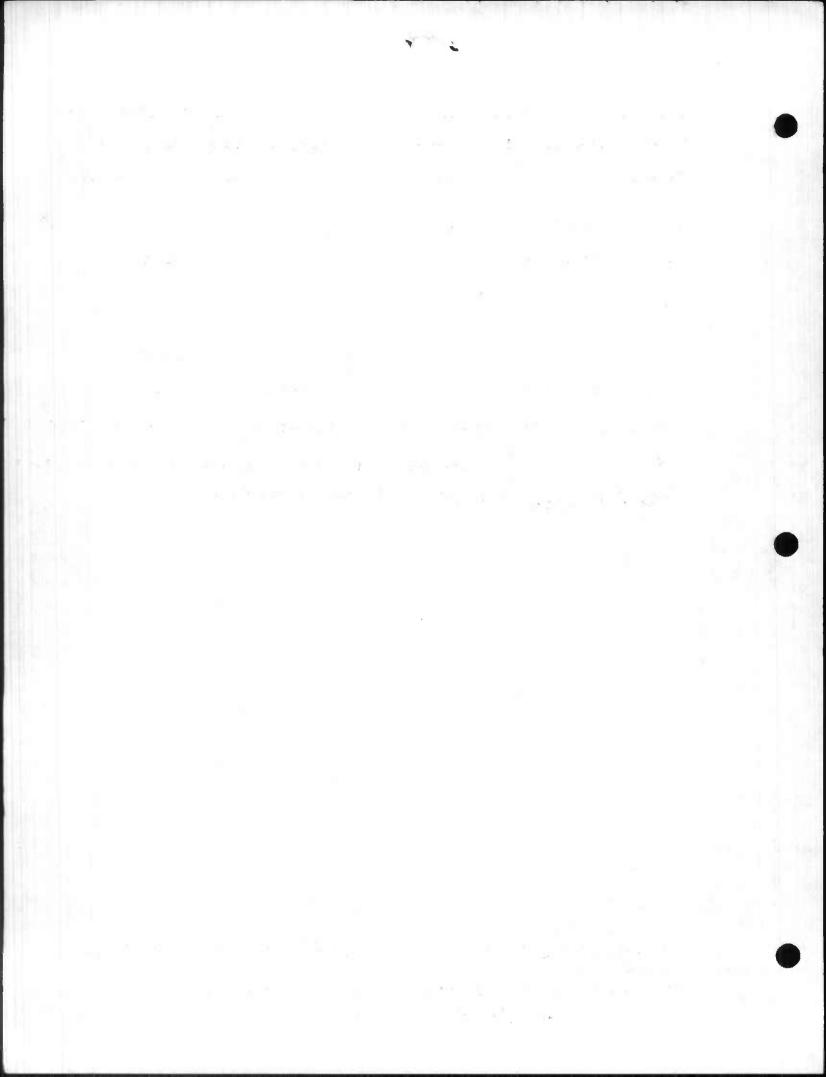
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number muchus JAW 20 OCME DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THANE MAGHUM.D An MO 21014 410-879-6564 218 FULF 32. Regist/ar's Signeture 31. Date filed (Month. Day, Year) State JAN 24 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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|-----------|------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------|---------------------------------|------------------------|-------------------------|-----------------------------------------------------|------------------------------------------|-------------------------------|--------------------------------------------|-------------------------------------------------------|-------------------|
| п | Dhuaiai | | Decedent's Nema (First, Middla. | Last) | | | | | | 2. Deta of De Month | eth Day | Yaar | 3. Tima | of Death |
| | Physici /Medio | cal | JACQUELINE CI 4a. Facility Nama (If not Institution, | | | YN | | | 4b. City, Town, or | Feb. | 06, 2 | 000 | 7: | 50PM |
| 7 | Examir | ier | Hazelwood(304 | | | 150 | | | Pocomok | | | | × | |
| Н | Funerai | | | | | . last birthday |) If Un | dar 1 Yaar | | | | | | or Foreign |
| | Director | | 213-22-6709 Usual Rasidance of Decadant | 1□M 2XF | 7 | 2 Yrs. | Month | ns Days | Hours Mir | 8. Data of Bi (Month, Di 04/29 | y, Year) /27 | Del | awar | e e |
| | h the Maryland r 28a-f show | 1 | 10a. Stata 10b. County | | 10c. Ci | ity, Town or L | ocation | | | | - | 1 | Od. Insida | |
| | | oto | MD Worces | ter | Poc | omoke | | | | | | | | s 2 No |
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| | death with the ms 23a or 28a | rai | 3047 Stockton | | | | | 1851 | | | USA | | | |
| 215-0020 | or ite | by Funeral Director | 11. Marital Status 1 Navar Married 2 Marrie 3 Widowed 4 Divorced | 12. Was Decedan Armed Forcas 1 Yas 2 If Yas, Give Yaar or Datas | ? No | J,S. 13. | | pecify Cub | Hispanic Origin? (ean, Maxican, Pua Specify: | Specify Yas or Norto Rican, etc.) | Specif | ce - Amaric ick, Whita, i y: Whit | atc. | |
| 2-0 | "natural", | ted | 15. Dacedent's | Education | | 16a. Dece | dant's U | sual Occu | petion during most of we | a delta a | 16b. Kind of B | | | |
| 21 | within one. | Completed | (Specify only highast Elamantary/Secondary (0-12) | College (1-4or | 5+) | lifa. | DO NOT | usa retire | during most or wo d) | onking | | | | |
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| Maryland | 0 = 0 5 | Be | 17. Fathar's Nama (First, Middla, L | | | | | | 18. Mothar's Na | ime (First, Middle | , Maidan Suman | na) | | |
| yla | should bud Menta | To | John Dawson C | larke | | | | | Hattie | · W | escott | | | |
| a | and and is ma | | 19a. Informant's Name/Reletionsh | p (Type, Print) | | 19b. Mall | ing Addre | ess (Stree | t and Number or R | Rural Routa Numb | er, City or Town | , State, Zip | Code) | |
| | other tr | | Dawson C. Lle | wellyn (S | | | | | ll Driv | e, Sal | isbury | , MD | 218 | 04 |
| ore | | | 20a. Mathod of Disposition 1 □ Burial 2 □ Cramation | Demoust from State | | Place of Disp cematary, cra | osition (fi | Vama of or other ple | ice) | Data | 20c. Location | - City or To | wn, Stata | |
| Ĕ | Page nent o int: If i | | 4 Donation 5 ☐ Other (Spe | ecify) | | tomy | Boa | rd c | of MD | 2/7/00 | Baltim | ore. | MD | 21201 |
| Baltimore | permit. Page Department of Important: If any injury or odde. | | 21. Signature of Fun ral Sarvice L | 40.0 | | 2 H | 2. Nama | and Addr | ass of Facility Melson | Funer | al Home | o P | Δ | |
| | - | | 23a. Part1. Entar tha disease, or c shock, or haart failura. List o | omolications that cause | nd the deet | th. Do not an | 03 | Lind | en Ave. | , Poco | moke C | ity, | MD | 21851 |
| | Dharatatan | | shock, or haart failura. List o | nly ona cause on each | lina. | in. Do not er | ntar tria ir | loga or gyl | ing, such as cardie | ic or respiratory a | irrast, | t I | Intervsi Be | etween d Death |
| 7 | Physician /Medical Examiner | | tmmediete Causa (Final disaasa or condition | Cot | Pore | erta | 2 | (| A u | ith | | < | 124 | encs |
| | LAdmine | | resulting in death) | | Dua to (| or as a conse | dñeuce o | of); | | , | 0 | | | |
| | D 45 | Examiner | | - b | | Mei | Lai | rasin | s to | Liver | and | i | | |
| | and trans | cam | Sequentially list conditions, | 0. | Due to (| or as a conse | quence d | of): | - | 0 | | | | |
| 9 | oe ex | | Sequantiatly list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants | | | 0+ | the | | ntern | al a | rean 1 | | | |
| 68760 | tificate be executed g physicien and as the burlal-transit | Medical | that initiated evants rasulting in death) Last | | Dua to (c | or as a conse | quance o | 1): | | | 1 | 1 | | |
| | 5 0 6 | Me | | d | | | | | | | | | | |
| Box | death cer e attendin | lan | · | _ 0 | | | | | | | | | | |
| | e de the s | Physician/R | Part II. Other algolificant condition | contributing to death | but not ras | sulting in the i | undariyin | g causa gi | van in Part I. | 23b. Did | tobacco use co | intribute to | the cause | e of death? |
| , P.O | ires that the death cen signed by the attendin d be detached for use | by Phy | | | | | | | | . 10 | Yee 2□ No | 3 Prot | onbly 4 | Unknown |
| Records, | nbe. | Completed b | | | | | | | | 24a. Was perf | an autopsy ormed? | EVE | ara autopsy allable prior mpletion of death? | ir to |
| Ä | 0 4 8 | E | | | | | | | | 10 | Yas 200 No | 10 | Yas 2 | □ No |
| Vital | | BeC | 25. Was cesa referred to medicat | | | | | | 28 Place of De | eath (Check only | /- | | , 100 20 | |
| > | | To B | axaminer? 1 ☐ Yas 2 No | Hospital; | ient 2 | ER/Outpatie | nt 3 | DOA Ot | har | Homa 5 Ras | | nas (Canaih | et. | |
| on of | ng Ph fter thi nneral | Certification: T | 27. Menner of Death 1 Neturet 5 ☐ Panding | 28a. Date of Inj (Month, D | | 28b. Time of Injury | ot | 28c. Inju | ry at | | how injury occur | | 9 . | |
| Division | f or Attending after death. Director: After In by the fune | Cat | 2 Accident invastiga 3 Suicida 8 Could no | t be | T | | М | | Yas 2 No | DOI Location | (04 | | 10- 1-11 | |
| <u>≥</u> | or A Direc | 호 | 4 ☐ Homicida datarmin | ed 28e. Piace of Ir building, e | nc. (Specil | oma, rami, si <i>fy)</i> | reet, fact | ory, oπice | | | Street and Numi wn, Stata) | per or Hura | HOUIB NU | mber, |
| | pital brail beliii | | One Continue and country | Th. 11 - T . 11 - 1 | | | | | | | | | | |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Medical | 29a. Cartifiar (Check only 2 Medical Ex | Physician: To the best caminer: On the basis and manner s | of axamina | wiedga, daat ation and/or ir | h occurre vastigati | on, in my | ma, data and plac opinion, daath occ | e, and dua to tha surred at tha tima, | deta and place, | end due to | ated. tha ceuse |)(s) |
| | To the To the Com | Σ | 29b. Signature and title of certified | h | 10 | | 2 | | sa number | | 29d. Data signe | d (Month, I | Day, Year) | |
| | | | · Children | 1 MD | | | | D | 0053 | 262 | 2/ | 7/00 | 0 | |
| | 8 | | 30. Nama end adurass of person w | ho completed ceuse of | death (Iter | n 23e) (Tvpe | Print) | | | | ~ | | | |
| | | | | , | | | • | 11+- | 104 5 | | - 011 | | 04- | |
| | Sta | te | John Whittake 31. Data fliad (Month, Day, Year) | 32. Regist | rar's Signa | ature / | | | | OCOMOK | e City | ,—MD- | 218 | 57 |
| | Registr | | FFB 0.7: | 2000 500 | March . | J. | Jan Jan | A Section | 2/ | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Month Day **Physician** CHARLES H. LINGENFELDER FEBRUARY 6, 200 0024 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 2-25-1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 MM 2□ F 212-18-9990 Director MARYLAND Usual Rasidence of Decedent 10a Stata 10h County 10c City Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director DELAWARE SUSSEX MILLSBORO ä 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 238 D-1 VIRGINIA STREET, LEISURE POINT 19966 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 72 hours after l Hygiens. other than "natural", or the ent, the Medical Examine 1 Never Married 2 Married 1 ☑ Yas 2 ☐ No If Yes, Give 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) PATROLMAN LAW ENFORCEMENT Maryland 18 Mother's Name (First Middle Maiden Sumeme) 17. Father's Nama (First, Middle, Last, Be Pages 1 and 2 should be I nent of Health and Mental JOHN T. LINGENFELDER KATHERINE BARNES 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) important: If Item 27 any injury or other to ANNA E. LINGENFELDER/WIFE D-1 VIRGINIA STREET, LEISURE PT., MILLSBORO, DE. 19966 Baltimore, 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, Stata cematery, crematory or other place)
MELSON'S CAPE HENLOPEN
CREMATORY 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

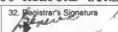
21. Signature of Funeral Service Licenses 2/7/00 FRANKFORD, DELAWARE 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD. LONG NECK ROAD, MILLSBORO, DELAWARE. 19966 Photo Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting In death) Intarction KilnesorM Examiner Due to (or as a consequence of): Examiner (himm Dile The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician the burial Box 68760, Dua to (or as a consequence of): Physician/Medical Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? P.O. 3 Probably 4 Unknown 1-Yes 2 No Records, þ 24b. Wara autopsy lindings available prior to Completed 24a. Was an autopsy complation of causa of death? page 2 1 ☐ Yas 2 ☐ No of Vital 25. Was casa referred to medical axaminar? 8 26. Piace of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 27. Mannar of Death 28d. Describe how injury occurred 28a. Deta of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? After Division or Attanding 5 Pending invastigation 1_2 Natural death. 1 ☐ Yas 2 ☐ No 2 Accident 24 hours after deal 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Certifler 15 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and mannar as stated. Medical completely (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. within 2 ş 29b. Signatura and fitla of certifier 29c. License number 29d. Data signed (Month. Day, Year) 0

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30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print)

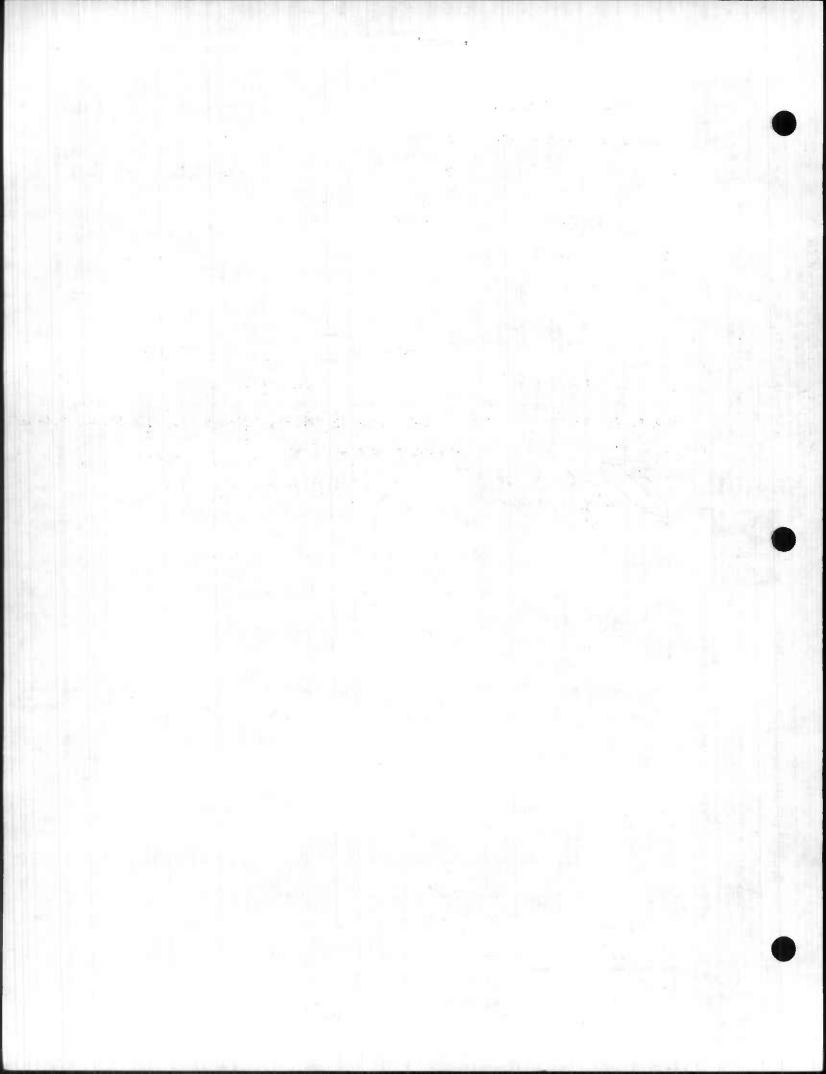
DR. STEVEN HEARNE, 106 MILFORD STREET, SALISBURY, MARYLAND. 21804

State Registrar FEB 1 0 2000





CHARLES



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death

1. Decedent's Nama (First, Middle, Last) 2. Data of Death February 2, 2000 **Physician** 4:00AM Lillian F. Lewis /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Adventist Bradford Oaks Nursing Home Clinton If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth 9. Birthplace (State or Fora) Yune 24,1920 Washington, DC 9. Birthplace (Stata or Foraign **Funeral** Hours 1□M 2FF Months Days 79 Director 578-12-2459 Usual Rasidence of Decedant the Maryland 10e Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2\0\No Director Prince George's Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b USA 20735 7129 Branchwood Place Berns 23a Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐No If Yas, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian Bleck, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is merked other ban "natural", or her any Injury or other traumstic awart the Mandesi F., or her 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 12th Collega (1-4or 5+) Pepco Stenographer 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Stella M. Carter Harry T. Mortimer 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Same as item 10 Gary C. Lewis/Son 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 X Burial 2 Cremetion 3 Removal from State Resurrection Cemetery 2/7/2000 Clinton, Md. 4 Donetion S ☐ Othar (Specify) 21. Signature of Funaral Service Licensee George P. Kalas Funeral Home, P.A. all 6160 Oxon Hill Rd. Oxon hill, Md. 20745 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical Examine Dua to (or as a consequence of): Physician/Medical Examiner the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Due to (or as a consequence of): 88 for use a signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 200 No 3 Probably 4 Unknown The law requires that by 24b. Ware autopsy findings available prior to completion of cause of death? should 24a. Was an autopsy performed? Completed page 2 1 Yas ZONo 1 ☐ Yas 2 ☐ No of Vital Physician: 25. Was casa ratarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Other: Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division or Attending 1 Naturel 2 Accident 5 Pending invastigation 1 ☐ Yas 2 ☐ No death. 6 Could not be datarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicida Medicai 29a. Cartifier 🖎 Certifying Physician: To tha best of my knowledge, daath occurred et tha tima, data and place, and dua to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

24 hours after deat Funeral Director: Hospital completely within 2. To the F 94

31. Data filed (Month, Day, Year) State FEB 0 4 2000 Registrar

Frank

29b. Signatura and title of certifier

M. Ryan, M.D. 11701 Livingston Rd. Ft. Washington, Md. 20744 32, Registrar's Signatura

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

License number

29d. Data signed (Month, Day, Year) February 3, 2000

10088 1 1 833 march 0588 1 1 833

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 05 177

| Physician | Decedent's Neme (First, Middle, Last) | / | 1 | | 2. Dete of Dea Month | th Dev | 3. Tima of Dea |
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| /Medical | Elsie E. | Lancas | ter | | Januar | | |
| Examiner | 4e Facility Neme (If not institution, give street end nu | imber) | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death |
| | Ft. Washington Hospita | al | | Ft. Wash | - | | e George's |
| Funeral Pirector | 5. Social Security Number 6. Sex 1 M 2 F | 7. Age (In yrs. las | t birthday) If Under 1 Yeer Months Days | | 8. Dete of Birth (Month, Day 8/4/18 | Year) | 9. Birthplace (State or Fo Country) Wash., D.C. |
| * | Usuet Residence of Decedent 10a. Stete 10b. County | 10c. City. | Town or Location | | | | 10d. Inside City Li |
| is marked other than "natural", or items 23s or 28s-f ahow raumatic avant, the Medical Exampler must be notified at To Be Completed by Funeral Director | Md. P.G. | | t. Washington | 1 | | | 1 ☑ Yes 2 ☐ |
| 280 | 10e. Street and Number | | 10f. Zip Code | | 1 | log. Citizen of V | What Country? |
| Funeral Director | 2902 Blooming Court | | | 20744 | | U.S | |
| Je L | 11. Meritel Stetus 12. Wes Dec Armed Fo | edent Ever in U,S. | 13. Was Decedent of If Yes, specify Cul | Hispanic Origin? (Sp | ecity Yes or No- | 14. Rec | e - American Indian, |
| y Fu | 1 Never Merried 2 Married 1 Yes | 2 No | 1 ☐ Yes 2 No | | ricali, etc.) | Specify | ck, White, etc. |
| Be Completed by | 15. Decedent's Education | | 16a. Decedent's Usual Occu | pation | | 16b. Kind of Bu | usiness/Industry |
| Be Complet | (Specify only highest grade completed) Elementery/Secondery (0-12) College (| | (Give kind of work done life. DO NOT use retin | during most of work | ing | | , |
| mo: | 11th | 1-401 54) | Seamstress | | | Tailor | ing |
| 90 | 17. Father'a Neme (First, Middle, Last) | | | 18. Mother's Nem | e (First, Middle, | Meiden Sumam | 99) |
| To | Frank Thomas | | | Mati | lda Will | liams | |
| | 19e. Informent's Neme/Reletionship (Type, Print) Rolando L. Hall/Grandson | | 19b. Meiling Address (Stree 2902 Blooms | | | | |
| once. To | 20e. Method of Disposition | 0.000 | ce of Disposition (Name of netery, cremetory or other plants | ace) | Dete | 20c. Location - | City or Town, Stele |
| | 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from 4 ☐ Donetion 5 ☐ Other (Specify) | | apeake Cremat | | 14/00 | Gree | enbelt,Md. |
| | 21. Signeture of Funeral Service Licensee | | | ess of Fecility ngton & S | | | |
| d | Xany W. Q | SOIT | H.S.Washi | ngton & S oughs Ave | ons Co. | Inc. | C 20019 |
| | 23a. Pert1. Enter the disease, or complications that of ahock, or heart feilure. List only one ceuse on a | caused the deeth. | | | | | Approximate |
| trans | | | nsive Ca. | diava | coula | v Pise | e ala |
| 2 | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last | Due to (or a | ardial s e consequence of): s a consequence of): s e consequence of): | diova | scule | r Pise | cose |
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| | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last | Due to (or ea | s a consequence of): s e consequence of): | | 23b. Did to | | |
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dev **Physician** ZOHRA LODHI 0119 2-2-2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Washington Adventist Hospital Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₽F Months Yrs. Director None Pakistan 2-19-27 **Usual Residence of Decedent** the Meryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f above the Madest Exemples must be notined as London 1 ☐ Yes 2 No Director England None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? England 8 57 Avenue Close N.W. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status filed within 72 hours effer 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: Asian þ 3⁄E Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker Masters . Peges 1 and 2 should be filed w tment of Heelth and Mantal Hygler tant: if Nem 27 Is marked other th Jury or other treumatic event, the Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Haq Nawaz Khan Fatima Khan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Amer Lodhi 14 Sutton Place S., New York, N.Y. 10022 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 15 Burial 2 Cremation 3 Removel from State permit. Pege Department of Important: If eny Injury or 2-5-2000 London, England 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 22. Name and Address of Facility UNIVERSAL MORTUARY INC. Funeral Service Licensee 411 Kennedy St, N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner the burlel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Box 68760, 0 Due to (or as a consequence of) for use es 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes 1 ☐ Yes 2 HNo 1 ☐ Yes 2 ☐ No Physicien: funerel director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2140 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s efter death. Il Director: After t od in by the funera Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mariner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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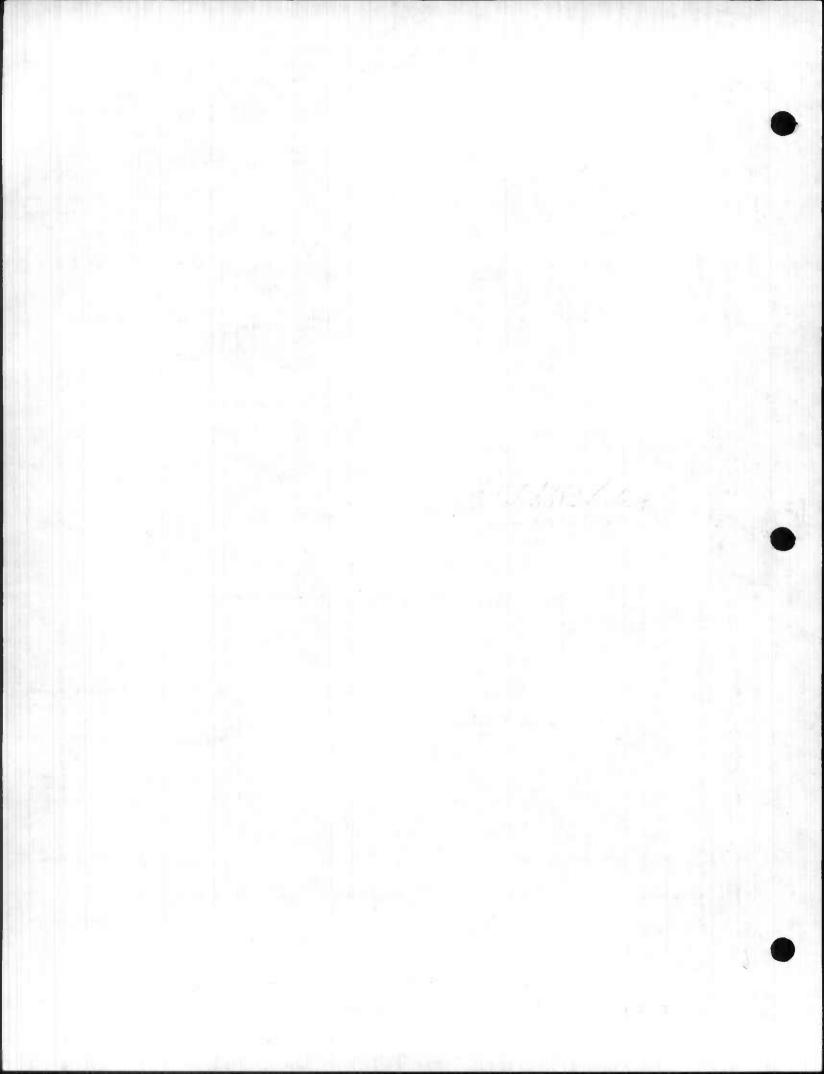
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** ANNA Μ. LLOYD February 4 2000 0030 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□ M 2 F 222-26-5429 94 **Director** 1-13-1906 Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show instiffed at 10a. State 10b. County 10d. Inside City Limits Delaware 1 Yes 2 No New Castle Middletown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 4595 Summit 19709 Bridge Rd. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Merital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White å 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Hygiene. Other then 'n Elamentery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flow 27 is marked offth any Injury or other traumatic event 2008. å NO RECORD NO RECORD 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Gorman 4595 summit Bridge Rd., Middletown, DE. 19709 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetary, crematory or other plece) Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Bethel cemetery 2-8-00 Chesapeake City, Md 21. Signature of Funeral Service Licer 22. Name end Address of Facility
DANIELS & HUTCHISON FUNERAL HOME 212 N. Broad St., Middletown, DE. 19709 23a. Part1. Enter the disease, or complications that caused in shock, or heart feilure. List only one cause on each limb. Approximate Interval Between Onset and Death deeth. Do not entar the mode of dying, such as cardiac or respiretory arrest, **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) auto responsible **Examiner** Dua to (or as a consequanca of); Examiner Due to (or es a consequence of): physician and s the burial-transit Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760 certificate be an/Medical Due to (or es e consequence of): 980 Physicia Pert tl. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yea 2 No 3 Probably 4 Unknown congestive heart faction Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Division of Vitai Be 25. Wes casa raferred to medical 26. Placa of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospitel: 1 Yas 2 XNo Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Day Year) funeral 27. Menner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Ne Hospital or Attending P in 24 hours after death. Ne Funeral Director: After t After 1 Natural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be datamined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier Medical (Check only within 2 100 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 216100 C10001534 Venta Gurano 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Kenneth Lewis, MD. 817 N. Broad st., Middletown, DE, 19709 31. Data filed (Month, Dey, Year) FEB 0 8 2000 32. Registrer's Signature State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 180

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Dev Year **Physician** James Huston Lamaster 9:00 PM 26, 2000 /Medical January 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES 1700 JASMINE TERRACE ADELPHI If Under 24 Hrs. 8. Date of Birth Jan Year 9. Birthplace (State or Foreign JANUARY 31, 1934 WEST VIRGINIA If Under 1 Year 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 65 236-44-4131 Director **Usual Residence of Decedent** the Meryland permit. Pages 1 end 2 should be flied within 72 hours efter death with the Merylan Department of Heelth and Mentel Hyglene.
Important: if item 27 is marked other than "natural", or items 23s or 28s-f show shiplury or other treumstic event, the Medical Examinar must be notified at once. 10a. State 10d. tnaide City Limits 10b. County 10c. City. Town or Location TY Yes 2 No Director MARYLAND PRINCE GEORGES ADELPHI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 JASMINE TERRACE 20783 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1XÖYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritat Status 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2X No Specify: Specity: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 TRUCK DRIVER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) EMERY LAMASTER RUTH GRIFFITH 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GAIL LAMASTER/SPOUSE 3507 DUKE STREET COLLEGE PARK, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremstion 3 ☐ Removel from State JAN. 29, 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 2000 BRENTWOOD, MARYLAND 21. Signature of Fymerat Service Licensee 22. Neme and Address of Facility ram & Wills FORT LINCOLN FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arest, and a cardiec or respiretory arest.

MARYIAND 20722 shock, or heart teilure. List only one cause on each line. Interval Between Onset end Desth **Physician** Immediste Cause (Final disease or condition resulting in death) /Medical a CARCINOMA OF LUNG Examiner Due to (or as a consequence of): Examiner physician and the buriel-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or es a consequenca of): . Box 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Tyvea 2 No 3 Probably 4 Unknown DIABETES The law requires that þ Records, 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? CORONARY ARTERY DISEASE page 2 PERIPHERAL VASCULAR DISEASE 1 Yes No 1 Yes 2 No of Vital 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1□ Yes 2□ No this funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Naturat
2 Accident Division or Attending 5 Pending investigation efter death.

Director: Aft
d in by the fur 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Hospital To the Hospital within 24 hours To the Funeral C completely filled edical (Check only 29b. Signature and title of ge 29c. License number 29d. Date signed (Month, Day, Year) D16495 JANUARY 28, 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 4701 RANDOLPH ROAD JOEL GOOZH, MD ROCKVILLE, MARYLAND 31. Date filed (Month, Day, Year) FEB 0 2 2000 sistrar's Signature State Registrar

I form to write

₹£8 û 2 2860

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 05 | 8 |

| | | | Certificate of | Death | Reg. N | No. | 0101 | | |
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| Physician | 1. Decedent's Name (First, Middla, Last) HELEN | Ho | LITT | LE 2 | . Data of Death | Day Year | 3. Tima of Death 10:45 AM | | |
| /Medical Examiner | 4a Facility Name (If not institution, giva street | and number) | | 4b. City, Town, or Loca | tion of Death | Ic. County of Death | 10.45 181 | | |
| | 1022 Park Avenue | | | Annapolis | | Anne Arund | el | | |
| Funeral Director | 5. Social Security Number 6. Sex 1 M 2 | 7. Aga (In yrs. last t | oirthday) If Under 1 Year Months Days | If Under 24 Hrs. 8 Hours Min. | Data of Birth (Month, Day, Yes Aug 31 1 | 9. Birthy Cou 916 Mary | olaca (Stata or Foreign ntry) Land | | |
| death with the Maryland ms 23a or 28a-f show rmust be notified at neral Director | Usual Residence of Decedent 10a. Stata 10b. County | 10c. City. To | wn or Location | | | 1 | 0d. Inside City Limits | | |
| or here 23s or 25s-t sho uniner, must be notified at Furneral Director | Maryland Anne Arundel | | nnapolis | | | 1 ☐ Yas 2 No | | | |
| a or 28e-f s it be notified if Director | 10e. Street and Number 1022 Park Avenue | | 10f. Zip Code 2140 | 3 | | 10g. Citizen of What Country? | | | |
| olner must Funeral | 11. Marital Status 12. W | is Decedent Evar in U,S. | | Hispanic Origin? (Specifian, Maxican, Puerto Ric | | USA 14. Race - Americ | | | |
| 6 | 1 Nevar Married 2 Married 1 [| ned Forces?] Yas 2√ No ′as, Giva Å ar or Dalas: | If Yes, specify Cub | | an, etc.) | Bleck, White, etc. Specify: White | | | |
| dical. | 15. Decedent's Education (Specify only highast grada com | | a. Decedent's Usual Occup (Giva kind of work dona | pation during most of working | 16b. | Kind of Business/In | dustry | | |
| A, the Medical. | | llege (1-4or 5+) | life. DO NOT use retire | d) | D | etail Busin | 000 | | |
| | 17. Fathar's Nama (First, Middla, Last) | | Clerk | 18. Mothar's Nama (F | | | 622 | | |
| To Be | James T. Ivey | | | Eva Benne | | No. | | | |
| - | 19a. Informant's Name/Ralationship (Type, Pr | nt) 15 | 9b. Meiling Address (Street | | | y or Town, Stata, Zip | Code) | | |
| | Judy Ann Bensinger/ Daugh | ter | 1022 Park Ave | . Annapolis, | Md. 21403 | | | | |
| r or other tr | 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovi | from Stata came | ot Disposition (Nama of tary, crematory or other pla | ce) | | Location - City or To | | | |
| in in | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligenses | HILL | rest Cemetery 22. Name and Addra | | | apolis, Mar Funeral Ho | | | |
| 906 | 13-66 | _ | | f Gloucester S | | | | | |
| to use as the burist-transit and state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th | | Dua to (or as | a consequence of): | HLURE | | | 1 MO. YEARS | | |
| the att | Part II. Other significant conditions contribution | g to death but not resulting | in the underlying cause gi | ven in Pert I. | 23b. Did tobac | co use contribute t | o the cause of death? | | |
| d by Physic | CORDINALY AK | tery ds | SP M3 | I. | 1)X(Yes | 2 No 3 Pro | bebly 4 Unknown | | |
| 2 shoul | | | | | 24a. Was an su performed? | av cc | ere autopsy tindings allable prior to empletion of cause death? | | |
| Com | | | | | 1□ Yas | 200 11 | □Yas 2□ No | | |
| Be Be | 25. Was casa retarred to medical examinar? | | | 26. Placa of Death (| Check only one) | | | | |
| 678 | 1 Yes 2 Hospita | 1 ☐ Inpatient 2 ☐ ER/C | Dutpatient 3LI DOA | | The second second | 6 □Other (Speci | (y) | | |
| To the Funerel Director: After this completely filled in by the funeral director. Medical Certification: To | 1 Naturel 5 Pending 2 Accident investigation | Data of Injury (Month, Day Year) Placa of Injury - At homa, building, atc. (Specify) | | Yes 2□No | d. Describe how in Location (Street City or Town, Sta | and Number or Run | al Route Number, | | |
| pletely fille | (Check only 2 Medicat Examiner: O | To the best of my knowled the basis of axaminetion a d manner steted. | | | | | | | |
| To the Funeral completely fillex Medical C | 29b. Signatura and title of centiler | 7 | 29c. Licens | se number | 29d. [| Date signed (Month, | Day, Year) | | |
| - | Metom | ~ W(Y) | $(/)_2$ | 3-142 | | 1/21/00 | | | |
| | 30. Nama and addrass of person who complete | d cause of death (Item 23a | (Type, Print) David | Krimmins MD | 3. KU | 21401 | | | |
| State | 31. Date tilad (JAN 2. 4°2000 | 32/Registrar's Signatura | 4 1 | , | | - | | | |
| Registrar | | | · BOOLK | | | | | | |

2:34

JAN 24 2000 Secret

Please Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) AMEND: #16b & 19a mcg 1/27/00 AA CO HE Centificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LAURA LEDAETTER Month **Physician** 0 00 3:30 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1□ M 20 F Yrs. 577-44-5866 Director 81-10 SOUTH CAROLIN Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or liens 23a or 28a-f ahow the Wedical Examiner must be notified at 112 Yes 2 No Director MARYLAND ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 508 Funeral BAY DALE COURT 21012 USA Race - American Indian, Black, White, etc. 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 20 Married 1 ☐ Yes XXNo If Yes, Give 1 Yes 2√ No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ARKANSAS BOARD OF Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) EDUCATION SCIENCE TEACHER

18. Mother's Name (First, Middle, Maiden Surname) other t 12th 7 yrs 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health, end Mental Hy Important: If Item 27 is married oth any Injury or other traumatic event any Injury or other traumatic event Be RICHARD GAMBRELL ANNIE MAE SAUNDERS (HUSBANDab. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HENRY D. LEDBETTER (HUSBAND) 508 BAY DALE COURT ARNOLD, MD. 21012 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XIXCremation 3 ☐ Removal from State METRO 1/26/2000 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY 21 Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

21401

22401

Approximate frilervel Between Onset and Death Ree **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner 7c BRSWCH1715 Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last will physician Physician/Medical the Due to (or as a consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2KINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only one)

The law requires that the death certificate be assouted Box 68760 P.0. Division of Vital Records, or Attending Physician: After To the Hospitan within 24 hours after deeth.
To the Funeral Director: A

deeth.

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sinpatient 2 ER/Outpatient 3 DOA 27. Menper of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 BNatural 5 Pending 1 Yes 2 No investigation 2 Accident

6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 T Homicide

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature and title

Um

30. Name and address of person who completed cause of death (Item 23a) (Type, Py) KRIHCUS

104 32. Registrar's Signature 21901

Registrar

Certification: To

Medical

31. Date filed (Month, Dey, Year)

JAN 2 7 2000 1000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) LANE, ST Physician 2030 KAYMOND Ames 4b. City, Town, or Location of Death 25 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 8. Data of Birth (Month, Day, IA Trublel MUNdar 24 Hrs (9ev 7. Aga (In yrs. last birthday) al Security Number Birthplaca (Stata or Foraign Country) **Funeral** OKIMO 2□ F Months Days Hours Min Yrs. 73 1926 MARYLAND AUG. **Director** 218-26-4462 Usual Rasidance of Decedent the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ms 23a or 28a-f show 1 Yas 2 □ No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? with 21403

13. Was Decedant of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Maxican, Puarto Rican, etc.) death Funeral COURT 12. Was Decedar USA 14. Raca - Amaricen Indian, 940 BAY FOREST 7 is marked other than "natural", or items traumatic event, the Medical Examiner m Was Decedant Evar in U.S. Armed Forcas? 1 IXYes 2 D No. 1 Yas, Give 955-75 Yaar or Datas: Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter ment of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural; or ite mry or other traumatic event, in: Manical Entire into yor other traumatic event, in: Manical Entire in yor other traumatic event, in: Manical Entire in yor other traumatic event, in: Manical Entire in yor other traumatic event, in: Manical Entire in your present and in the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of th 1 Navar Married 2 Married Specify: BLACK Maryland 21215-0020 1 ☐ Yas 2X No Specify: þ 3 □ Widowed 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) DEPARTMENT OF Elementary/Secondary (0-12) Collega (1-4or 5+) 12th 0 FEDERAL PROTECTIVE OFFICER 17. Father's Nama (First, Middla, Lest) 18. Mother's Nama (First, Middla, Maidan Sumame) Be HENRY LANE KATHERINE AYTCH 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) ZELDIA LANE (WIFE) 24 HALF PENNY LANE BALTIMORE, MD. 21228 Baltimore, 20b. Place of Disposition (Nama of cametery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata XXBurial 2 Cramation 3 Ramoval from Stata Department Important: If any Injury or MARYLAND VETERAN 2/1/2000 CROWNSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensee 22 Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Lavr WEST ST. ANNAPOLIS, MD. 21401

Approximate Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not antal shock, or hear failure. List only one cause on each line. **Physician** Heart Disease Immediata Causa (Finel disaasa or condition rasulting in daath) /Medical Examiner Examiner bete physician and the burial-transit Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Due to (or es e consequence of): that the deeth certificate be exec Box 68760. Physician/Medical Dua to (or as a consequance of): 98 950 signed by the e 23b. Did tobacco use contribute to the ceuee of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Yhknown Aq 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? page 2 s 185 1□ Yes 2□ No 1 ☐ Yas 2 ☐ No Hospital or Attanding Physician: 25. Wes cese referred to medical axaminar?
100 Yas 2 □ No Be 26. Placa of Daath (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 0 1 ☐ Inpatient 2 NER/Outpatient 3 ☐ DOA funeral 27. Manner of Deeth 28a. Deta of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury et Work? Certification: 5 Pending death. 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide 29a. Cartifier 1__Cartifying Physician: To tha best of my knowledga, daath occurred et the time, dete end plece, and dua to the cause(s) and manner as stated. Medical completely (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner stated. within 2 To the reputy 29d. Date signed (Month, Day, Year) 4 mo ceusa of daath (Item 23a) (Typa, Print) and address of parson who complete 5 America

DNES

32. Registrar's Signatura

mD

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State

Registrar

e filad (Month, Day, Year)

JAN 28

29a. Cartifier

(Check on)

29b. Signature and title of certifie

31. Data filed (Month, Day, Year)

U.S.

FEB 19

2000

and addrass of person who completed causa of death (Itam 23a) (Type, Print)

32. Registrar's Signature

Medical

State Registrar 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.

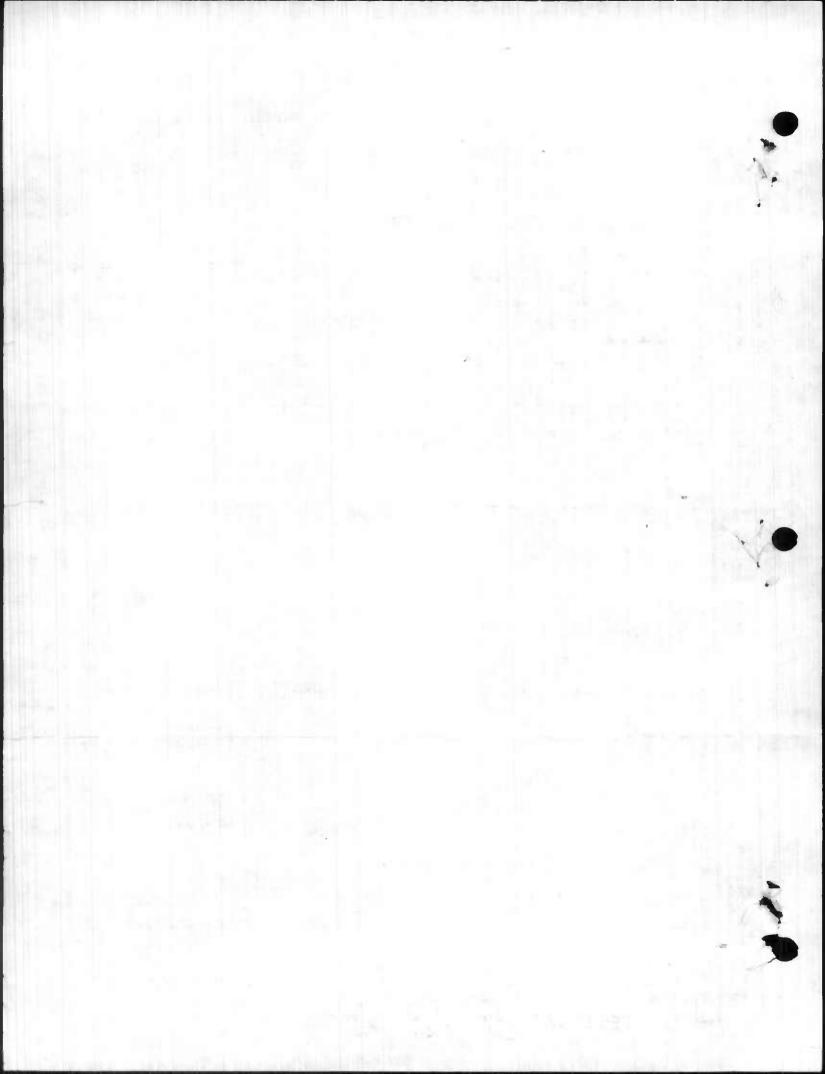
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

February 13, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | | | , | Cer | tificate of | | Workar in | Reg. No. | 0 0 5 | 5184 |
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| П | | | 1. Decedent's Name (First, Mi | ddle, La | st) | | | | | 2. Date of D | eath | | 3. Time of Death |
| | Physici /Medi | | Edith Emma 1 | iee | | | | | | Januar | Day 31, 2 | Year 2000 10 | 0:30 p.m. |
| | Examir | | 4e. Facility Nama (If not institu | | | | | | 4b. City, Town, or | | th 4c. County | y of Death | |
| 1 | | | Anne Arundel | Med | ical Cente | er | | | Annapo | olis | Anne A | | undel |
| | Funeral Director | | 5. Social Security Number 216–74–6773 | 6. 5 | □M 2XF | ge (In yrs. last b 76 | Yrs. | If Under 1 Year Months Days | | 8. Date of B (Month, D Apr 12 | lay, Year) | 9. Birthplace Country) Virgin | e (State or Foraign) nia |
| | pur * | | Usual Residence of Decedent 10a. State 10b. Cou | ntv | | 10c. City, To | um or I oo | ation | | | 4041100 | | |
| | eho eho | 5 | | • | Arundel | Edgew | | ation | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐No | | |
| | the N | Director | 10e. Street and Number | ше | ALGIGEL | Lagew | acer | 404 71- 0-4- | | | 10g. Citizen of What Country? | | |
| | ath with 23a or nust be | rai Dir | 61 Beach Dr: | ive | | | | 10f. Zip Coda 21037 | - | | USA | | |
| 21215-0020 | 72 hours after death with the Maryland "naturel", or items 23s or 28s-f show idical Eventinet must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Ma | | 12. Was Decedent Armed Forcas? 1 Yas 2 I if Yes, Give Year or Dates: | | | /as Decedent of I Yas, specify Cub □ Yes 2ऒ No | Hispanic Origin? (S ean, Maxican, Puerl Specify: | pecify Yas or N to Rican, etc.) | 5 Specif | ca - American i ack, White, etc. fy: Whi | |
| 5-(| | Completed | 15. Deced (Specify only hig | iant's Ed | ducation ide completed) | 16 | a. Decede | ent's Usual Occup | pation during most of wo | rkina | 16b. Kind of B | Business/Indust | try |
| 2 | | npidu | Elamantary/Secondary (0-12 | | College (1-4or | 5+) | | | during most of word) | | | | |
| 2 | e filed within II Hygiene. other than | S | 12 | | | | Home | maker | | | Home | | |
| Maryland | 9 4 5 5 | Be | 17. Fether's Name (First, Midd | |) | | | | 18. Mother's Nar | ne (First, Middle | e, Maiden Sumar | ne) | |
| Y | should be nd Mental marked o | 2 | Lert Comer | | | | | | Biddle | | | | |
| Va | 2 6 6 | | 19a, Informent's Name/Ralation | onship (| Type, Print) | 19 | | | and Number or Ru | | | | xde) |
| | an and | | Josephine Gro | oss/ | daughter | | | | rive, Ed | - | | 037 | |
| Ore | DSBILLMOTE, permit. Peges 1 ar Department of Hea Important: If item; any injury or other once. | | 20a. Mathod of Disposition 1 Straight 2 ☐ Crematic | n 3 | Removal from State | 20b. Place cemet | of Dispos e <i>ry, cr</i> em | ition (Name of atory or other pla | ce) | Date | 20c. Location | - City or Town, | , Stata |
| E | | | 4 ☐ Donation 5 ☐ Other | y) | Laker | nont | Memoria | l Garden | 2000 s | | sonvill | • | |
| <u>a</u> | | | Lakemont Memorial Gardens 2000 Davidso 1. Spring of Fundam Services Courses 2. Name and Address of Facility Barranco & Sons, P.A. Severna Park | | | | | | | | | | 1 11 |
| •• | | | 495 Gov. Ritchie Hwy., Severna Park, MD 2114 | | | | | | | | | | |
| | Physician ¹ | | 23a Party Enter the disease book, or heart failure. I | Com | plications that cause | the death. Do | not ante | r the mode of dyl | ng, such as cardia | or raspiratory | arrest, | Ap | pproximate |
| | | | Spook, or regart failure. I | Jac Only | one cause on each ii | ne. | | | | | | Or | térval Batween nset and Death |
| 2 | /Medical | | immediate Cause (Final | | 1 | | - C |) | | | | 7 | DAYS |
| | Examiner | (| disease or condition resulting in death) | | a ASRICL | | | | NIA. | | | | 0473 |
| | | Jer. | | | | Dua to (or as a | s consequ | ance or): | | | | 1 | |
| | icate be executed physician and s the burial-transit | Examine | Convention by the same distance | | b. ———— | Dua to (or as a | 0.0000000 | 10000 of). | | | | 1 | |
| Ć, | exec n an ial-tr | Exa | Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury | | | Dua to tor as a | Corrsaqu | erice oi). | | | | į. | |
| 68760, | death certificate be executed e attending physician and of for use as the burial-transit | cai | triat trittated events | < | c | Due to for each | 0000000 | A. | | | | | |
| 89 | ficat g phy as th | Medical | resulting in death) Last | | Due to (or as a | consequ | ence or): | | | | | | |
| Box | eath certific attending pl | lan/M | | | d | | | | | | | | |
| m | seath atte | cia | Dod II. Other slouidleant and | lala | | | 1 | 4 -1 - | | - 001 71 | | | |
| O. | that the de led by the a detached t | Physic | Part II. Other significant cond | | | | in tha un | derlying cause gr | ven in Part I. | | | | e cause of death? |
| ٩. | that ed b | | ATRIAL FI | 30 | MATIC | ,J | | | | 1 | Yes 2 No | 3 Probab | bly 4 Unknown |
| of Vital Records, | w requires that the been signed by the should be detache | d by | | | | | | | | 24a Wa | s an autopsy | 24b. Wera | autopsy findings |
| Ö | | ete | | | | | | | | | formed? | avallat | bla prior to letion of cause |
| 36 | e la hes ye 2 | Completed | | | | | | | | | | of dea | ith? |
| <u></u> | : The l | | | | | | | | | 1 🗆 | Yes No | 1 🗆 Ye | es 2 No |
| N N | Physician: The this certificate ral director, peg | Be | 25. Was casa rafarred to med axeminer? | cal | Hoonital | | | 0 | 26. Place of Dec | ath (Check only | one) | | |
| of | Physic this c | 2 | 1 Yas No | | Hospital: Inpatie | | | 3LI DOM | | | idence 6 Ott | | |
| L C | Viter | on: | 27. Manner of Death Naturel 5 ☐ Pan | ding | 28a. Data of Inju (Month, Da | y Year) 28b. | Tima of Injury | 28c. Inju Wo | | 28d. Dascribe | how Injury occur | rred | |
| Sic | leath lor: / the f | cat | 2 Accident Inve | stigation | | | | M 1 | Yes 2□No | | | | |
| Division | her d frect frect n by | Certification: | | rmined | 286. Placa of Inj | ury - At homa, f c. <i>(Specify)</i> | arm, stre | et, factory, office | | | (Street and Num own, State) | ber or Rural Ro | oute Number, |
| | ital c | | | | | | | | | | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune. | edicai | 29a. Certifier Certification (Check only one) | al Exan | ysician: To the best ninar: On the basis of and mannar st | f examination a ated. | nd/or Inve | estigation, in my | opinion, daath occu | rred at the time | , date and place, | , and dua to the | e causa(s) |
| | roth Mithir Toth | X | 29b. Signature and title of cert | fior | | | | 29c, Licans | sa number | | 29d. Date signe | ed (Month, Day | y, Year) |
| | | | | 8 | | | | D3 | 9037 | | 1/3 | 1/00 | 2 |
| | | - | 20 Name and address of a con- | na mira | nompleted as | looth /line: 55 | (T | rina) | | | . 1 | | |
| | | | 30. Neme and addrass of pers | ori wno (| Omplated cause of d | eath (item 23a) | (Type, P | 100 | of Man | 1116 | חזה | Same | ANIC ME |
| | | 10 | DOUGLAS S 31. Date filed (Month, Day, Ye | ar) | complated cause of d | ar's Signature | ~ Z / | - KONUT | القار العاد | ي درد | NIVE, | -100A | CUS I |
| | Sta Registr | - | FEB (| 9 2 | חחח ב | and a | 19 | An | del | | | | |
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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Rea No 1. Decedent'a Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month **Physician** CALLIE M. January 26 2000 7:05 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hill Haven Nursing Home Adelphi If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 TF 350-10-0005 99 Director August 1, 1900 Mississippi Usual Rasidence of Decedant 10a. Stete 10c. City. Town or Location 10b Counts 10d. Inside City Limits 28a-f show must be notified at Prince George's Adelphi 1 No 2 No Mary land Director 2 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ð U.S.A. 3210 Powder Mill Road 20903 Berne 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Yaer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yas 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Administrative Assistant 4 Years permit. Pages 1 and 2 should be file.
Department of health and Mental Hyg.
Important: If Nem 27 is marked
any injury or other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Be Dorthula Gilmer Rev. Jesse Washington Wimbush 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ratationship (Type, Print) 13016 Hathoway, Silver Spring, Maryland 20906 Beverly Lee Reid/Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 02/05 1 ☐ Burial 2 ☐ Cremetion 3 ☑ Ramovet from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Washington Memory Gardens 2000 Glenwood, Illinois 21. Signatura of Funaral Sarvice Licensea J. B. JENKINS FUNERAL HOME Nancu 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final Atherosclerosis 15 Years disaasa or conditio resulting in daath) Examiner Dua to (or as a consequence of): Examiner be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Ceuse (Diseas or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): that the death certificate 950 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the cause of death? P.O. the bet 2 1 Yes 2 No 3 Probably 4 ☑ Unknow Dementia signed t Records, py 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director. Be 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) To 1 Yas 2 No this 27. Mannar of Death 28d. Describe how injury occurred Certification: 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Panding Invastigation 1 X Natural n 24 hours after death. Ne Funeral Director: Aft pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide ò Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) January 31, 2000 D - 31563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, MD, 11251 Lockwood Drive, Silver Spring, Maryland 20901

DHMH 16 Rev 6/95

State Registrar 31. Deta filed (Month, Day, Year) FEB 0 1 2000

32. Registrar's Signatura

FER 3 1 2000 Street 19 1 2000

| • | To the Hosotte | within 24 hours To the Funeral completely file | Martinal |
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| (5 | J | N | 1010 |
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| | 1 Decadentic No | me (First, Middle, | l est) | | Cer | tificate of | Death | 2. Date of Dea | Reg. No. | 2 | Time of Death |
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| | | | rive street and number, | | | | 4b. City, Town, or L | | | | -12441 |
| | Docto | rs Comm | unity Hos | pita | 1 | | Lanham | | Princ | ce Geo | rge |
| | 5. Social Security 577 28 | 5693 | Sex 1 □ M 2 N F | ge (In yrs 85 | last birthday) Yrs. | If Under 1 Year Months Days | | 8. Dete of Birth (Month, Day 2 / 2 0 | | 9. Birthplaca Country) Alab | (Stete or Forei |
| | Usual Residence 10a. State | of Decedent | | 10c. City | y, Town or Lo | cation | | | | 10d. li | nside City Limi |
| TOTAL DISCOURT | ма | Daring | a Caamaa | | | Madah | 4.0 | | | 1 | Yes 20N |
| | M d 10e. Street and N | | e George | 1 08 | pira | Heigh 10f. Zip Code | LS | | 10g. Citizen of | What Country? | |
| | 1202 | Chapal | Oaks Driv | 7e | | 2074 | 3 | | U. S | S.A. | |
| | 11. Marital Status | | 12. Was Decedent Armed Forces | Ever in U, | S. 13. V | Ves Decedent of I | Hispanic Origin? (Spoan, Mexican, Puerto | ecify Yes or No- | 14. Rec | ca - Amarican In | ndian, |
| 1 | | erried 2 Merried | 1 ☐ Yes 2)() If Yes, Give | | | ☐ Yes 2☐ No | | , , , , , , | Specif | | |
| | 3 kd Widowed | I 4 □ Divorced | Year or Detes: | | | Λ | | | | у втас. | |
| | | 15. Decedent's ecify only highest (| trade completed) | | (Give | ent's Usuel Occu kind of work done OO NOT use retire | during most of work | ring | 160, Kind of B | lusiness/Industr | У |
| | Elementary/Se 8 E h | condary (0-12) | College (1-4or | 5+) | | | vernment | Emp. | Secr | retary | |
| | 17. Father's Name | e (First, Middle, La | st) | | | | 18. Mother's Nam | e (First, Middle, | | | |
| | Marvin | | Bryant | | | | Hattie | | Midd | leton | |
| | 19a. Informant's | Name/Reletionship | | | 19b. Mailin | g Address (Stree | t end Number or Rur | ral Route Numbe | | | le) |
| | Eugene | | nde, Sor | | 8924 | 91st | Place, I | | | | 20706 |
| | 20a. Method of D | | ☐Removel from Stete | | tece of Dispo emetery, cren | sition (Neme of netory or other pla | ace) | Date | 20c. Location | - City or Town, | Stete |
| 4 Donation 5 Other (Specify) 121. Signature of Funeral Service Licensee 22. Neme and Address of Facility 23. Signature of Funeral Service Licensee | | | | | | | | | | Maryla | nd |
| | 21. Signature of I | Funeral Service Lic | ensee | | *22 H | AT.T. BR | OTHERS F | UNERAL. | HOME | | |
| | HALL BROTHERS FUNERAL HOME 621 Florida Ave., N.W., Wash, D.C. 20 239 Bell February and Completing that council to death Doord order the mode of dains such as cardiac or receivation arrest. | | | | | | | | | | |
| | 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. | | | | | | | | | | proximate rvel Between set and Deeth |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2, 2000 **Physician** Mary Jane Mitzel 2:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Harford Memorial Hospital If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug. 16, 1926 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 2ØF Mary Land 217-20-6602 72 Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 288-7 Maryland Harford Joppa 10f. Zip Code 10a Street and Number 10g. Citizen of What Country? 23a or 21085 USA 200 Duryea Drive Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Rece - American Indian, 11 Marital Statue Black, White, etc. 72 hours after 1 Never Married 2X Married 21215-0020 8 1 ☐ Yes 2 ☑ No Specify: 3 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 Claims Adjuster Insurance Co. Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be h and Mental Helen Althea Coniff Francis Anthony Kreiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nam 27 l 200 Duryea Drive, Joppa, Maryland 21085 Harry P. Mitzel/ Husband altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Grdn, 2-4-00 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? hes 1 Yes 2 No this certificate director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? After 1 A Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the fi the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Check only Medical 29c. License number 29d. Dete signed (Month, Day, Year) 2000 cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

FEB 3

2000

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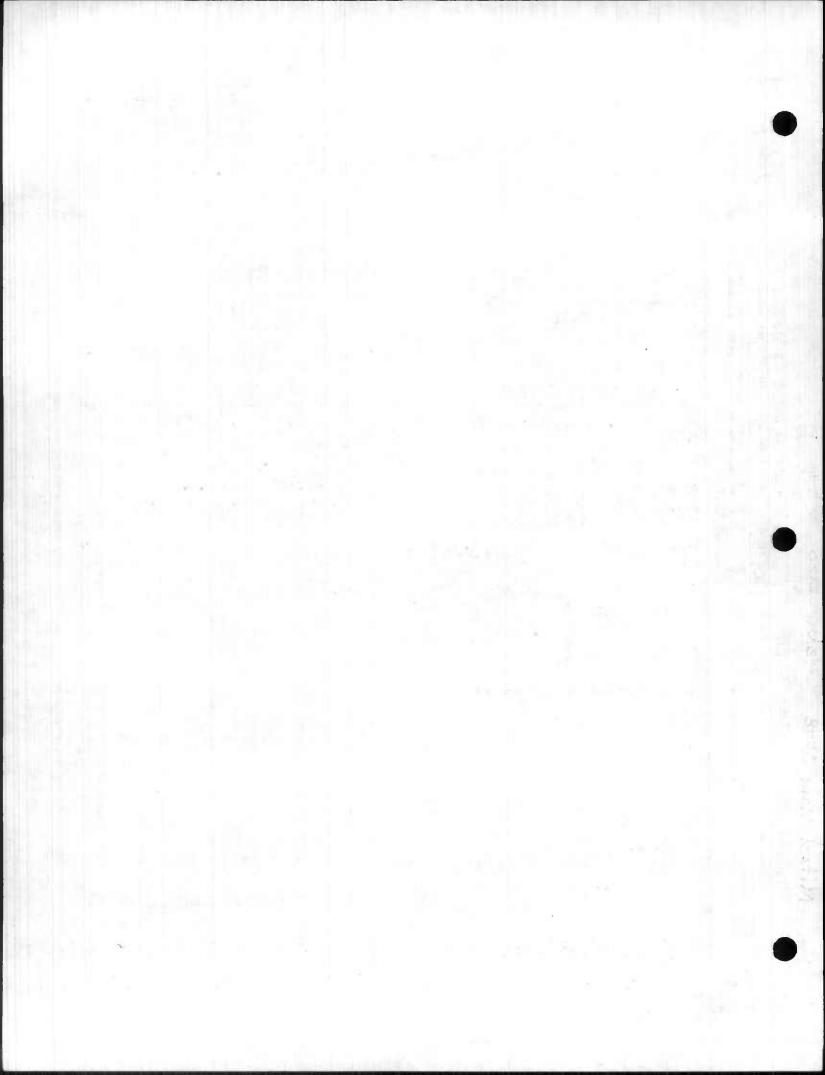
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Mary

Mitzel

BUSINESS

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dev **Physician** January 25, 2000 9:50 p.m. Supplee Constance McKee /Medical 4e Facility Name (If not Institution, give street end number) 4h City Town, or Location of Deeth 4c. County of Deeth Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Yrs. Jan. 28, 1906 Virginia Director 218-30-4743 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or itema 23a or 28a-f ehow other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 B No Director Maryland St. Mary's Charlotte Hall 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 United States death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritel Stetus Black, Whita, etc. 72 hours after 1 Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Yeer or Detes:1943-45 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Important: if then 27 te marked other than "n eny Injury or other treuments." Elementery/Secondary (0-12) College (1-4or 5+) U.S. Government Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Mildred White Deverle Joseph E. Supplee 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) Coletta Haliscak / Friend 21526 South Essex Drive, Lexington Park, MD 20653 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 1-29-00 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funerel Service (icensee 22. Name end Address of Facility Brinsfield Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heef tailore. List only one cause on each line. 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finet diseese or condition resulting in deeth) Examiner Examiner omm burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Bud more mu attending physician for use es the buna Box 68760 runar> certificate be Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequence of) 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings svailable prior to Completed 24a. Was an autopsy performed? peeu completion of cause of death? 1 Yes 2 18 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case reterred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: To the Mospital or Attending P within 24 hours after death.
To the Funeral Director: After t Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not ba 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certified 50653 Jan 26 - 2000 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) COM AN Surona DV Deale Churchton Dad

DHMH 16 Rev 6/95

State Registrar

32. Registrar's Signeture

FEB. 13 2000 Server

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | Ce | rtifica | te of l | Death | | Reg. | No. | UU | 120 |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------------------|----------------------|--------------------|----------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------|-----------------------|-------------------------------|--------------------------------------------------------------|
| Physician | Decedent's Name (First, Middle, Las | | | | | | | 2. Date | | Day, | Year | 3. Time of Death 29 : 50 |
| /Medical Examiner | 4a Facility Name (If not institution, give | EMERSON street and number) | | MOOF | RE | 4 | b. City, Town, or | | | 4c. County | of Death | |
| | Saint Joseph 5. Social Security Number 6. So | | | ter ast birthday) | If Unde | or 1 Year | Tow | | of Birth | | Balti | |
| Funeral Director | | № М 2□ F | 77 | Yrs. | Months | Days | Hours Min. | 7/2 | Date of Birth (Mogth, Day, Year) 7/23/1922 9. Birthplace (State or Foreign Country) Illinois | | | |
| 28a-f show notified at rector | 10a. State 10b. County | ford | 10c. City | , Town or Lo | ocation | | רים | 10d. Inside City Lim | | | | |
| 28a-f s notified actor | | Tora | | | 101.7 | 0.4 | Bel | AIL | 40- | Onter a 111 | | |
| 28 0 | 10a. Street and Number 108 Seevue C | ourt | Apt | . D | 107. 21 | p Code | 21014 | | 10g. | | Vhat Country | |
| if, or thems 23 caminer must by Funeral | 11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedeni Armed Forces? 1 M Yes 2 I If Yes, Give Year or Dates: | No | | Was Dece If Yes, spe | | ispanic Origin? (5 n, Mexican, Puer Specify: | Specify Yes o to Rican, etc | or No- | | e - Americar ck, White, et | |
| | 15. Decedent's Ed (Specify only highest grad | ucation | WW | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | | | | | |
| Hygiens. ther than "nature ent, the Medical. a Completed | Elementary/Secondary (0-12) | College (1-4or ! | 5+) | | | | f Sale | S | | | Indus | try |
| al H | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mother's Na | me (First, M | iddle, Mai | den Suman | 10) | |
| To To | William 19a. Informant's Name/Relationship (7 | Type Print) | Di | ckers | | s /Street | . Ed | ith | lumher C | ity or Town | | nder |
| 4000 | Madeleine Moor | 4 | | - | | | | | | ny or rown, | Olaro, Esp O | 000) |
| 4 5 5 | 20a. Method of Disposition | e \ MITE | 20b. Pl | lece of Dispo | sition (Na | ame of | 10 a,b | Dete | | c. Location - | City or Town | n, State |
| nent of my or o | 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify | | | ametery, cre | | | ardens | 2000 |) Be | l Air | r. Ma | rvland |
| Department imports any injuice. | 21. Signature of Funeral Service Licens | sol / | 1 | | 2. Name a | nd Addres | ss of Facility urtz & tsvill | Son | Fun | eral | | |
| Medical xaminer | Immediate Cause (Final disease or condition resulting in death) BILATERAL BRONCHOPNEUMONIA a | | | | | | | | | | 1 | 2 WEE |
| g physician end as the bural-transit fedical Examiner | | | | | | | | | | 3 | | |
| | | d | | | | | | | | | | |
| ched for | Part II. Other algnificant conditions co | | ut not resu | Iting in the u | inderlying | cause giv | en in Part I. | 23b. | | | | he causs of dea |
| 5.2 5 | POLYP ASCENDING | COLON | | | | | | | 1 U Yes | 28J No | | bly 4□Unkn |
| ate has been signed by the attendir, page 2 should be detached for use | <u> </u> | | | | | | | 24a. | Was an a performed | utopsy d? | avail | autopsy finding able prior to pletion of cause ath? |
| | | | | | | | | | 1 Yes | 2□ No | 1 🖾 | Yes 2□ No |
| r this certificate and director, past | 25. Was case referred to medical examiner? | Hospital: | | | | OA Oth | 28. Place of De | | | | | |
| | 1 ☐ Yes 2 € No 27. Manner of Death | 1 N Inpatie | | ER/Outpatie 28b. Time o | | On | 4 🗆 (4013#19 I | | | e 6 Oth | | |
| fund fund | 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Inju (Month, Da | y Year) | Injury | м | 28c. Injun Worl | k? Yes 2 □ No | 200. 003. | 10011011 | mijory coool | | |
| r death. ector: A by the f by the f | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Inj building, et | ury - At ho c. (Specify | me, farm, st | reet, facto | ry, office | | 28f. Local City of | ion (Street or Town, S | et and Numb State) | per or Rural i | Route Number, |
| SPE TO | | pician: To the best | of my knov | viedge, deat ion and/or in | h occurred | d at the tim | ne, date and plac pinion, death occ | e, and due to urred at the | the caus | se(s) and ma | anner as sta and due to t | ted. he cause(s) |
| Et hours afte Funeral Din stely filled in I | (Check only 2 MacKal Exact | | nt n d | | | | | | | | | |
| thin 24 hours afte the Funeral Dira mpletely filled in I Medical Cert | (Check only 2 Machinal Example one) | ener: On the basis of and manner str | ated. | | 20 | c. License | number | | 29d | Dele signe | d (Month, Di | ay, Year) |
| n 24 hou he Funer pletely fil edical | (Check only 2 Madical Exact | | ated. | | | D 44 | | | 29d. | Dele signe | d (Month, D | ay, Year) |
| within 24 hours afte To the Funeral Dire completely filled in I Medical Cert | (Check only 2 had been and 190 of certified 29b. Signeture and 190 of certified 30. Name and address of person who c | and manner st | leath (Item | 23a) (Type, | Print) | D 44 | | MD a | 2 | 12/0 | d (Month, Di | ay, Year) |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05191 Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Deta of Death 3. Time of Death **Physician** Month Ann Louise Mitchel Jan.21, 2000 11:50 AM /Medicai 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner 202 Briar Cliff Lane Bel Air Harford If Undar 1 Year | if Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funerai** Days Hours 1 M 2 F Yrs. 283-42-6108 Director Jan.11, 1903 Ohio Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor treumatic event, the Modical Express must be notilised as 1 Yas 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 202 Briar Cliff Lane 21014 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Giva Yaar or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, White, atc. filed within 72 hours effer Hygiene. Ther than *natural', or Ite 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 s 1 and 2 should be filed w f Health and Mental Hygies frem 27 Is marked other ti Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumema) Be Michael u/k Lucas u/k Anna 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2.
Department of Health at
Important: If Item 27 Is
any Injury or other treu 202 Briar Cliff Lane, Bel Air, Maryland 21014 bets 20c. Location - City or Town, Stete D. Joyce Appel- Daughter 20a. Method of Disposition Puriel 2 Cramation 3 Removel from Stete 4 Donation 5 Other (Specify) Bel Air Memorial Gardens 01/25/2000 Bel Air, Maryland 21. Signature of Euperei Servica Licensee 22. Neme end Address of Facility McComas Funeral Home, P.A. 23e. Pert 1. Enter the full bease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest,

Approximate Approximate Interval Between Onset and Deeth Physician Cerebrovascular Accident /Medical Immediete Ceuse (Finei week disease or condition rasulting in death) Examiner Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): attending physician for use as the buria Box 68760 requires that the death certificate be Physician/Medicai Due to (or as a consequence of): P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributs to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, b 24b. Were autopsy findings avellable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 1 Yas 2 PNo 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Wes case refarred to medical Be 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 10 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Haturel 5 Pending Investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Couid not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. Medical 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) JANUARY 21, 2000 D350/2 30. Neme and address of person who completed causa of death (Itam 23a) (Type, Print) S Bel Air, Md. 21014 J. Kevin Lynch - MD 2 North AVC. 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State JAN 2 4 2000 > Registrar

Fv,

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Tima of Deeth Month BENNY MILLS 2 6 00 0138 4e. Fecility Nema (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY Birthpleca (State or Foreign Country) 5. Sociel Security Number If Under 1 Year Deta of Birth (Month, Dey, Yeer) 6. Sex Age (In yrs. lest birthday) 1₩ 2□ F Days Hours 214-42-8P2J Usuel Residence of Decedent 5 Yrs. MD 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of Whet Country? 10f. Zip Code 402 SN 218 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 1966 17 Yes, Give Year or Detes: 1273 Raca - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced 1973 BLACK 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Medical 12 th grade 17. Fether's Name (First, Middle, Last) VUrse Milltan 18. Mother's Neme (First, Middle, Maiden Sumeme) unarles copatra EURNSON 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Typ Stockton, My, 2/5k Barbara 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20a. Mathod of Disposition Burlal 2 Cremetion 3 Removal from State oolspring Cemetary 4 Donation 5 Other (Spacify) 22. Name end Adu 21. Signeture of Funerel Service Licansee me end Address of Feellity 23e. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 1851 nate Approximate Intervat Bet Onset end Deeth tmmediate Ceuse (Finet disaasa or condition resulting in deeth) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of) Sequentially tist conditions, if eny, leeding to Immediate cause. Entar Underlying Cause (Disees or Injury thef initieted events resulting in deeth) Lest Due to (or as a consequence of): Due to (or es a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings eveitable prior to completion of cause of death? 24a. Wes en eutopsy performed? 26. Piece of Deeth (Check only one)

The lew requires that the death certificete be executed P.O. Box 68760. Records, Division of Vital Hospital or Attending Physician:

Physiclan/Medical by Be Completed Certification: To

Medical

State Registrar

Examiner

the buriel-transit ate has been signed by the ettending p page 2 should be detached for use es certificate director. this the funeral After efter death. Director: Af filled in by

Physician

/Medicai

Examiner

Funeral Director

Completed by

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23s or 28s-f show any or other treumstic event, the Mental Exception may be notified at any or other treumstic event, the Mental Exception Transit by notified at

Department of important: If any injury or

Physician /Medical

Examiner

21215-0020

Baltimore, Maryland

25. Was case referred to medical examinar?
YE Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ tripatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner as steted. 2 Medical Examiner: On the basis of examination end/or trivestigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end mennar stated.

29b. Signeture end title of certifier

29d. Dete signed (Month, Dey, Year) 29c. License number

Jun 56

D0003599

21804

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

DME

2/7/00

SALISBURY, MD.

JOHN T. BULKELEY, MD 31. Dete filed (Month, Dey, Yeer)

FEB 09

106 MILFORD ST #201 32. Registrar's Signeture

To the Hospital within 24 hours e

completely

engaged probat, we codige

CS_____00-0850-003 MAR

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

| 1. Decedent's Name (First, Middle | , Last) | | | | | | | 2. Date of | | BV | | Time of Death |
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--------------------------------------------------------------------------------------|
| MARY McG | HEE | | | | | | | | | | | 1:42 P.M |
| 4a Facility Name (If not institution | , give street and nur | nber) | | | 4 | lb. City, To | own, or Lo | cation of De | ath 4 | c. County | of Death | |
| | | | | | | | | | | ANNE | | |
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| | | 69 | 118. | | L | | | FEB. | 25 1 | 930 | MARYL | AND |
| 10a. State 10b. County | | 10c. Ci | ity, Town or Lo | cation | | | | | | | 10d. le | nside City Limits |
| | | | | | | | | | | Yes 2□No | | |
| | ARUNDEL | | ENTON | 10f. Zii | n Code | | | | 10a. C | lizen of V | Mhat Country? | |
| | | | | | | | | | , og. o | | That Country ! | |
| | | | 15 13 | | | | ioin? (Sne | acifu Ves or I | No. | | e - American In | dien |
| | Armed Fo | rces? | , | If Yes, spe | city Cuba | n, Mexicar | n, Puerto Rican, etc.) | | | Black, Whita, etc. | | 1 |
| 3XXWidowed 4 □ Divorced | If Yes, Giv | ' B | 1 1 1 | 1 Yes | 2 🕅 No | Specify: | | | | Specify | BLACK | |
| 15. Decedent | | | 16a. Decedent's Usual Occupation | | | | | | 16b. I | Cind of Bu | usiness/Industr | 1 |
| | 1 | 4== 5 -1 | (Give | kind of wo | ork done i ise retired | during mos f) | t of worki | ing | | | | |
| | | -40(5+) | | OOK | | | | | RES | TAII | RANT | |
| | | - | | JOON | | 18. Mothe | er's Name | (First, Midd | | | | |
| ZENKE O C | ATTOMAY | | | TO STEVEN THE SE | | | | | | FD | | |
| | | | 19b. Meitir | ng Addres | s (Street | | | | | | State, Zip Cod | 0) |
| RODNEY GALLOW | AY (NEPH | EW) | | | | | | | | | | |
| | | | | | | | | Date | 7 | | | |
| | | State | | | | | b | /14/2 | 000 | BAT. | TIMORE | MD |
| | | 1115 | - | | | | 1 | 14/2 | 900 | DAD | TITORE | , IID. |
| | | | | | | | | | | | . A . | |
| | 1.7. | | 8.7 | 1 W | EST | ST. | ANN | APOLT. | S. N | | 21401 | |
| | b | Due to (or as a consequence of): Due to (or as e consequence of): | | | | | | | | | | |
| ceuse. Enter Underlying Cause (Disease or injury that initiated events | с | Due to (c | or as a conseq | uence of): | | | | | | | | |
| resulting in death) Last | d | | | | | | | | | | | |
| Part II. Other significant conditio | ns contributing to de | eath but not res | sulting in the u | nderlying (| cause giv | en in Part I | 1. | 23b. Did tobacco use contribute to th | | | ntribute to the | cause of death? |
| | | | | | | | | 11 | ☐ Yes | 2□ No | 3 Probably | 4 Onknown |
| | | | | | | | | | | opsy | comple | utopsy findings e prior to tion of cause |
| | | | | | | | | 10 | Was : | □ No | 1 □ Yes | 2 □ No |
| 25. Was case referred to medical | | | | | | 26 Place | of Death | | | | | |
| axaminer? 1 ☑Yes 2 ☐ No | Hospital: | noatient 2 | EB/Outpatier | 1 3 D | OA Oth | or- | | | | 6 DOth | er (Snacify) | |
| 27. Manner of Death | 28a. Date o | | 28b. Time of | | | | | | | | | |
| - Laurentin | | n, Day Year) | Injury | М | | | No | | | | | |
| 3 Suicide 6 Could r | ned Zou. Fillion | of Injury - At h | ome, ferm, str | eet, fector | y, office | | 1 | | | | per or Rural Ros | ute Number. |
| (Check only 2 Medical I | cominer: On the be | sis of examina | | | | | | | | | | |
| - 8 | and men | olatod. | | 29 | c. Licens | e number | | | 29d. D | ate signe | d (Month, Dav. | Year) |
| .eu. Signame and title of certifier 29c. License number | | | | | | | | | | | | |
| O.C.M.E. FEBRUARY 11, 2000 | | | | | | | | | | 2000 | | |
| 30. Name and address of person v | March 16 | W/ | | | 0 | .C.M. | <u>E.</u> | | FIE | BRUA | RY 11. | 2000 |
| | 4a Facility Name (If not institution NORTH ARUNDEL HO 5. Social Security Number 212-26-7923 Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE 10e. Street and Number 654 OLD WAUG 11. Marital Status 1 Never Married Privorced 15. Decedent (Specity only highes Elementary/Secondary (0-12) 7 th 17. Father's Name (First, Middle, Interpretation of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the privorced of the p | 4s Facility Name (If not institution, give street and nur NORTH ARUNDEL HOSPITAL) 5. Social Security Number 6. Sex 212-26-7923 1 M 2 F 21 Louis Residence of Decedent 10a. State 10b. County MARYLAND ANNE ARUNDEL 10e. Street and Number 6.54 OLD WAUGH CHAPEL 11. Marital Status 1 Never Married Diverced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7. Th 17. Father's Name (First, Middle, Last) ZEAKE O. GALLOWAY 19a. Informant's Name/Relationship (Type, Print) RODNEY GALLOWAY (NEPH 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from: 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22a. Part1. Enter the disease, or complications that coshock, or heart failure. List only one cause one shock, or heart failure. List only one cause one condition resulting in death) 25. Was case referred to medical disease or condition fresulting in death) 26. Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) 27. Magner of Death Cause (Final disease or conditions fresulting in death) Last 28. Date (Morital Could not be determined) 29. Certifier (Check only one) 20. Medical Examiner: On the be and man death on the determined of the publicant of the publicant of the publicant of the publicant of Could not be determined and man death on the determined of the publicant of the publicant of Could not be determined and man death on the publicant of the publicant of Could not be determined and man death on the publicant of the publicant of the publicant of Could not be and man death of the publicant of the publicant of Could not be and man death of the publicant of the publicant of the publicant of Could not be and man death of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of the publicant of | 48 Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL 5. Social Security Number 6. 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Social Security Number 6. Sex 1 | As Facility Name (if not institution, give street and number) | 46. City, To NORTH ARUNDEL HOSPITAL 5. Social Security Number 6. Ser 1 M 28 F 6.9 Vrs. Months Days Hours 21.2 – 26 – 7.92.3 | 46. City, Town, or Let NoRTH ARUNDEL HOSPITAL 5. Social Security Number 212 - 26 - 79 2 3 1 | 46. City, Town, or Location of De NORTH ARUNDEL HOSPITAL 5 Social Security Number 6 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 11 Security Number 12 Social Security Number 13 Security Number 14 Social Security Number 15 Security Number 16 Social Security Number 17 Social Security Number 18 Security Number 19 Social Security Number 19 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security Number 10 Social Security N | MARY MCGHEE # Facility Name (if not insulation, give street and number) NORTH ARNINGEL HOSPITAL 5. 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Social Sourity Number 2. 2. 2 - 2 - 7 - 9 2 3 1 | MARY MCGHE # Actility Name (find stateblions, give attent and number) NORTH ARINDEL HOSPITAL 5 Social Society Number 2.12 - 26 - 79 23 Umus Placedoner of Decident 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 11 Locusity 11 Locusity 11 Locusity 12 Locusity 12 Locusity 13 Locusity 14 Fact 15 Locusity 16 Locusity 16 Locusity 17 Locusity 18 Locusity 18 Locusity 19 Locusity 19 Locusity 19 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 10 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 11 Locusity 12 Locusity 13 Locusity 14 Locusity 15 Locusity 15 Locusity 16 Locusity 17 Locusity 18 Locusity 18 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusity 19 Locusi | AREADY AMERICAN DELL HOSPITAL FERRUARY 5, 2000 AREADY Name of a coster of beauth or survively NORTH ARUNDEL HOSPITAL Social Society Number 6 Sever 10 M 23P F 7, Age (fin yrs. set brinday) Usual Revidence of Decedent Local State Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Local Decedent Lo |

FEB 1 8 2000 James B fract

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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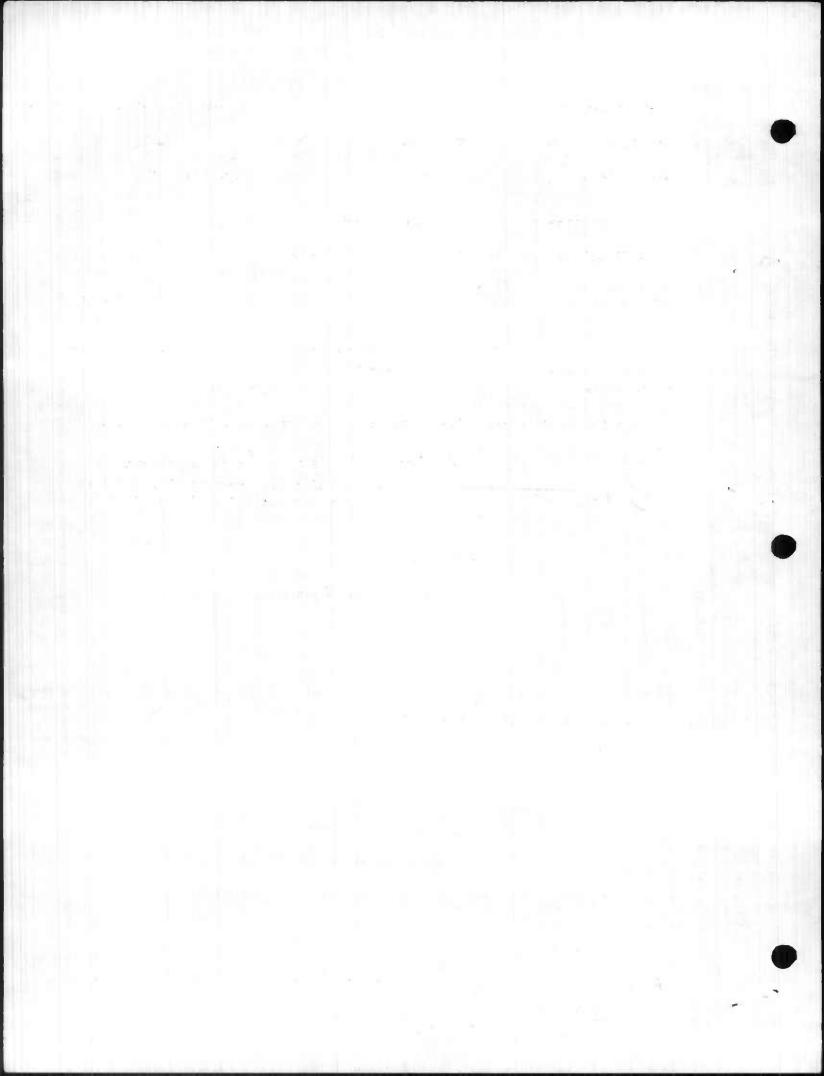
| | | | | | Ce | rtifica | ate of | Death | | | Reg. No. | | 00137 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------|--------------------------------|----------------------------------------------------|----------------------|------------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------|-----------------------------------------|--|
| | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of Do | eath Day | Year | 3. Time of Death | |
| Physicia: /Medica | | Arabella Mur | phy | | | | | | | Januar | y 25,2 | | 2:00 P.M | |
| Examine | - | 4a Facility Name (If not institution, | give street end no | ım <i>ber)</i> | | | | 4b. City, To | wn, or Lo | cation of Dea | th 4c. Cou | unty of Death | | |
| | | Prince Georges | Hospital | Center | | | | Cheve | erly | | Prin | ce Geo | rges | |
| Funeral | | | Sex | 7. Age (In yrs. | |) If Unc | ler 1 Year s Days | | 24 Hrs. | 8. Date of Bi (Month, D pril 2 | rth ay, Year) | 9. Birthe | place (State or Foreign | |
| Director | _ | 244-12-1781 | 1□M 2√F | 82 | Yrs. | -1.112 | | | A | pril 2 | 2,1917 | North | Carolina | |
| pg a | - | Usual Residence of Decedent 10e. Stete 10b. County | | 10c C | ty, Town or L | ocation | | | | | | | 10d. Inside City Limits | |
| e Maryti | | Washington,DC | | i i | ingtor | | С. | | | | | | 1□Yes 2□No | |
| G G | 9 | 10e. Street and Number | 2 2 | | | | Zip Code | | | 10g. Citizen of What Country? | | | | |
| 23a | <u>e</u> | 4815 Jay Street | N.E. | | | | 0019 | | | | U.S.A | • | | |
| 72 hours after death with the Maryland "natural", or frems 23e or 28e-f show rules! Examiner must be notified at | by Funeral Director | 11. Merital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced | Armed F | 24 No ive | J,S. 13. | | | Hispanic Ori ean, Mexical Specify: | | Specify Yes or No- rto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black | | | | |
| 2 hou | | 15. Decedent's | | | 16a. Dec | edent's Us | sual Occur | pation | - | - | 16b. Kind o | d Business/In | dustry | |
| C | Completed | (Specify only highest | grade completed) | | (Giv | (Give kind of work done life. DO NOT use retire | | | during most of working | | | 16b. Kind of Business/Industry | | |
| should be filled within nd Mental Hygiene. marked other than " imatic event, the Me | E | Elementery/Secondery (0-12) | College (| (1-4or 5+) | Exam | iner | | | | | Bureau | of En | graving | |
| H H H | | 17. Father's Neme (First, Middle, La | ist) | | | | | 18. Mothe | er'a Name | (First, Middle | | | 0 | |
| d be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be cod be code be cod be cod be cod be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code be code b | o Be | George Patrick | | | | | | Heti | tie H | lpieght | | | | |
| and Mental a marked o | - | 19a. Informent's Neme/Reletionshi | (Tyne Print) | | 19h Mai | ing Addre | es (Street | | | Il Route Numl | | wn State Zir | 1 Code) | |
| train train | | the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | - J | | | | | | | | | | |
| Heel Heel Cher | | Eugene D. Murphy Oa. Method of Disposition | / nusba | 20b. | Place of Disc | osition (A | lame of | | sning | Date D | | on - City or To | own, State | |
| permit. Peges 1 and 2 Department of Heelth a Important: If Item 27 Is any Injury or other tra once. | | XX Buriel 2 Cremetion 3 4 Donetion 5 Other (Spe | city) | State | | oln C | emet | ery Fe | | ary 5, | | | | |
| Departiment Important International | 3 | Functure of Funeral Service Li | Sensee C | 10000 | | | | ess of Facili nsburg | Ft. | Linco Brent | | | | |
| | + | 23a. Pert1. Enter the distance, or co shock, or heart failure. List or | omplications that | caused the dee | | | | | | | | 1 | Approximate | |
| Physician | | shock, or neart taller. List or | ny one cause on | eech line. | | | | | | | | | Interval Between Onset and Death | |
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| Examiner | | disease or condition resulting in deeth) Due to (or as a consequence of): | | | | | | | | | | | TWO NUTS | |
| | e | | C |) | | . A | n). | | | | | 1 | Tu | |
| d ansit | Ē | | b | NEUI | or as a conse | | ۸. | | | | | - 1 | ING DAYS | |
| ding physician and use as the burial-transi | Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying | 0. | / | 0 40 4 001136 | quario 0 | | | | | | | 0 | |
| Sicia bur | | Cause (Diseese or injury that initiated events | c. LU | LMON | ARY or as a conse | | DI | EMIL | | _ | _ | | UNE DAY | |
| ding physician and se as the burial-transit | VMedical | resulting in death) Last | ■ d | D0 00 (0 | or as a conse | quence o | ·). | | | | | | | |
| for u | Physician | | | | | | | | | 1 200 200 | | 1 | | |
| ed by the detached | 28 | Pert II. Other algolificant condition | contributing to d | leath but not res | sulting in the | underlying |) ceuse gi | ven in Part | 1. | 30.00 | | | o the cause of death? | |
| igned by | | | | | | | | | | 1 | Yes 20Th | io 3 Pro | bebly 4 Unknown | |
| 0 P 1 | d Dy | | | | | | | | | 24a Wa | s an autopsy | 24b. W | ere autopsy findings | |
| been signed by the should be detached | Completed | | | | | | | | | | omed? | av | vailable prior to empletion of cause | |
| ste has b | dr. | | | | | | | | | | | of | death? | |
| page page | 5 | | | | | | | | | 10 | Yes 28N | 0 1 | Yes 2 No | |
| | | 25. Wes case referred to medical examiner? | | | | | | | e of Deeth | (Check only | one) | | | |
| 00 | 0 | 1 Yes 2 110 | Hospitel: | Inpatient 2 | ER/Outpatie | int 3 🗆 1 | DOA O | her: 4 N | ursing Ho | me 5 Res | idence 8 🗆 | Other (Specif | fy) | |
| h. After thi funeral | 2 | 27. Menner of Death | 28a. Dete | of Injury | 28b. Time | of | 28c. Inju | ry at | | 28d. Describe | how injury oc | curred | | |
| leath. tor: Af the fu | a a | 2 ☐ Accident investige | tion | | | M | | Yes 2 | No | _ | | | | |
| after death. Director: After d in by the fune | Certification | 3 Suicide 6 Could no 4 Homicide determin | ad 289. Pieci | a of Injury - At h ling, etc. (Speci | | treet, fect | ory, office | | | | (Street and Nown, State) | umber or Run | al Route Number, | |
| Hospi 4 hou Funer tely fill | | 29e. Certifier (Check only one) Cortifying | Physician: To the aminer: On the b | best of my kno basis of examine | owledge, dea etion and/or i | th occurre | d at the ti | me, date ar opinion, dea | nd place, a | and due to the ed at the time | cause(s) and date and pla | I manner as s ce, and due to | stated. o the cause(s) | |
| within 2 To the comple | | 29b. Signature and title of certifiers | A 1 | indi sizioo. | | 1 2 | 9c. Licen | se number | | | 29d. Dete si | gned (Month, | Day, Year) | |
| F 3 F 8 | | b 1/1 | 1. 1 | *** | ~ | | 2 | 10 | 0 1 | -15 | 11. | 1/ | 17 | |
| (10) | | 10 11 | | m | MD | | 14 | -6) | 7/ | | 1-/2 | 20/0 | 207 | |
| (10) | 1 | 30. Nama and address of person wi | o completed cau | se of death (Ite | n 23a) (Type | , Print) | | | 100 | 1 0 | 1 | 15.00 | DEN 20706 | |
| | | NDUBUISI F | CHUFU | 51 M | D - | 174 | -U | Sott | VSUN | HU | . 66 | ONTO | עוין ייסע | |
| State | 7 | 31. Date filed (Month, Dey, Year) | | legistrar's Sign | erure | | | -week | | | | | | |
| Registra | | | EPE 2 | The same of the last of | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 31, 2000 January 5:50AM William S. Mitchell /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington Fort Washington Hospital Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Yeard May 11, 1932 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplaca (State or Foreign **Funeral** Months Hours 1√2 M 2□ F Days Washington, DC Yrs. 67 579-36-9462 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 1 ☐ Yes 2 🗓 No Fort Washington Directo Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flarms 23a or must be 20744 8837 Oak Lane USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, White, etc. 1 Yes 2 No Korean 1 Never Married 20 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced War Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto parts Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If frem 27 is marked off 88 Louise Deavers Samuel T. Mitchell 2 19a. tnformant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 Is any injury or other trau Same as item 10 Hassie H. Mitchell/Wife 20b. Placa of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Ft. Lincoln Cemetery 14 Burial 2 Cremation 3 Removel from State 02/03/2000 Brentwood, Md. 4 Donation Other (Specify) 22. Name and Address of Facility
George P. Kalas Funeral Home, P.A. 21. Signature of uneral Service Licenses Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intarval Between Onset end Death **Physician** /Medical tmmediate Cause (Final · NON-HODGKINS disease or condition resulting in death) Examiner Examiner HEART FAILURE OHGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. physician ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Physician/Medical the Due to (or as a consequenca of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 | Yes 2 | No 3 | Probably 4 | Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director. Be 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No Certification: To 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accident investigation MIA 1 Yes 2 No NIA 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide NIA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. edical 29a. Certifie (Check only one) To the I within 2 To the I Σ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deam (Item 23a) (Type, Print) Victor Herry, M.D. 1-31-2000 1170/ LIVINGSTON Rd MD FORT WASHINGTON 20744 31. Date filed (Month, Day, Year) FEB 0 1 2000 32. Registrar's Signature State Registrar

| | | | | | C | ertifica | te of | Death | | Re | g. No. | | | |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------|--------------------------------|------------------------|-------------------------------|---------------------------------|-----------------------|----------------------|----------------------------------------|-----------------|------------------------------------|-----------------------------------------------------|-------------|
| 4 | 1. Decedant's Name | e (First, Middla, La | st) | | | | | | | 2. Data of Death Month | Day | Yaar | 3. Tima | of Death |
| Physician /Medical | FRANCES | MILLER | | | | | | | | January | 07 00 | | 4:0 | 5 PM |
| Examiner | 4a Facility Name (f | not institution, giv | a street and number | or) | | | | 4b. City, Tov | wn, or Lo | cation of Death | 4c. County | of Death | | |
| | Brighton | n Gardens | s of Tuck | erman | Lane | | | Beth | esda | 1 | Montg | gomer | 7 | |
| Funeral Director | 5. Social Security N 578-50- Usual Residance of | 1693 | ax □M 2 X F | Aga (In yrs. | last birthda 98 Yrs | Month | ar 1 Yaar s Days | If Undar 2 Hours | Min. | 8. Data of Birth (Month, Day, Aug. 17, | Yaar) 1901 | Coun | lece (State try) W YO | or Foreign |
| ž == | 10a. Stata | 10b. County | | 10c. Ctt | y, Town or | Location | | | | | | 10 | Od. Insida | City Limits |
| se-feh offind s | MD | Montgome | ery | N | orth | Bethe | | | | | | s 2 No | | |
| observation notified specified notified funeral Director | 10e. Street and Nur 5809 Ni | | Lane, Apt | . 150 | 5 | | ip Coda 0852: | -5709 | | 10 | g. Citizen of V | S.A. | iry? | |
| by by | 3 X Vidowed | ed 2 Married | 12. Was Decede Armed Force 1 Tyes 24 If Yas, Giva Yaar or Data: | s? 9 No | ,S. 1 | | edent of t ecify Cub 2 No | | gin? (Sp , Puarto | ecify Yas or No- Rican, etc.) | Blac | e - Amarica ek, Whita, a Whi | atc. | |
| r, the Medical I | /Space | 15. Decedant's Edify only highast gra | ducation | | | cedant's Us | | pation during most | of work | | 6b. Kind of Bu | usinass/Ind | ustry | |
| M ed | Elamantary/Seco | | College (1-4c | or 5+) | lift | a. DO NOT | usa retire | ed) | or work | 9 | D | 0 | | |
| Comp | | | 2 | | 0 | wner/ | Opera | ator | | | Retail | Gro | ery | |
| 9 e | 17. Fethar's Nama | First, Middle, Last, |) | | | | | 18. Mothe | r's Nem | e (First, Middla, M | laiden Suman | ne) | | |
| | Rubin W | exler | | | | | | | | e Karp | | | | |
| eumatic e | 19a, Informant's Ne | | | | | | | | | al Routa Number, | | | | |
| 5 | Phyllis | Miller I | Peikin/da | ughte | r 580 | 9 Nic | hols | on Lan | e, A | Apt. 1505 | 5, N. H | Bethe | sda, | MD |
| ury or other tre | 7 | | Ramoval from Sta | ta | ematary, o | sposition (Noramatory of anon | othar pla | | J | Data 30, 2000 | Adelph | | | |
| Important: If any injury or once. | 21. Signatura of Fu | neral Sarvice Licar | nsee | | | | | | | Memorial Rockvi | Chapel | Ls, I | nc. | |
| anding physician and use as the bunel-trensit in/Medical Examiner | disaasa or condition rasulting in death) Sequentially list confirm, light confirmed to light confirmed to light causa. Enter Unda Causa (Disaase or that initiated evants rasulting in death) I | nditions, madiata rlying Injury | a | Due to (c | or as a con | sequence o | Zent 1): | fail | mo | | | | | |
| d for use | Part II. Other aignif | cant conditions c | ontributing to daeth | but not res | ulting In th | e underlying | causa di | ivan in Part I. | | 23b. Dld tol | bacco use co | ntribute to | the ceus | e of death? |
| be deteched for us by Physician/ | COA | | | | | | | | | 1 🗆 Ye | 2 No | 3 Prot | ombly 4[| Unknow |
| z snould | af | kerosclo | rus when | | | | | | | 24a. Was er perform | | COL | ara eutops ailable prio mpletion of death? | or to |
| Com | | | | | | | | | | 1□ Ya | s 2 No | 10 | Yes 2 | PLNo |
| o o | 25. Wes case refer | red to medical | | | | | | 26. Placa | of Deat | h (Check only one | a) | | | |
| I direct | examinar? | No | Hospital: 1 ☐ Inpa | atient 2 | ER/Outpa | tient 3 🗆 | DOA Ot | har: 4 Nu | rsing Ho | ma 5 🗆 Resida | nca 8 🗆 Oth | ar (Specify | y) | |
| | 27. Manner of Deetl 1 Matural 2 Accident | 5 Pending invastigation | | njury Da <i>y Year)</i> | 28b. Tim inju | | 28c. Inju | | | 28d. Dascribe ho | | | | |
| etely filled in by the funeraction: | 3 Sulcida 4 Homicide | 6 Could not b | 28a. Placa of | Injury - At he atc. (Specif | oma, ferm y) | street, fact | ory, offica | | | 28f. Location (Str City or Town | | oer or Rura | l Routa Nu | ımber, |
| pletely fill edical | 29a. Cartifiar (Check only one) | | ysician: To the be- niner: On tha basis and mannar | of axamine | | | | | | | | | | ı(s) |
| \$ ≥ | 29b. Signature and title of cartifiar 29c. Licar | | | | | | | | | 29 | d. Data signa | | Day, Year) |) |
|), |) a | | ermo | | | | D3 | 1282 | • | | 2/10 | 100 | | |
| 15 | 30. Nama and address | | complated causa o | daeth (Itan | n 23a) (Ty | pe, Print) | nue. | Suite | 10 | 5 Beth | es en n | 0 | rosi | 14 |
| State | 31. Data filed (Mon | | | strar's Signa | | 4 | 1 | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | | Certificate of | Death | Re | ig. No. | 0191 | |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------|-------------------------------------------------------------------|------------------------------------------------------------------------------|--|
| | Physician /Medical | Decedent's Name (First, Middle, Last) MARIE MARABLE | | | | 2. Date of Death | 1 1° 2000 | 3. Time of Death 11:07PM | |
| | Examiner | 4a Facility Name (If not institution, give s | | 13.5 | 4b. City, Town, or Lo | | 4c. County of Death | | |
| - | 5 | WASHINGTON ADVE | 7. Age (In yrs. las | | TAKOMA F | 8. Date of Birth | MONTGOMI | SRY place (State or Foreign | |
| | Funeral Director | | M 212 90 | Yrs. Months Days | Hours Min. | April 19, | 1909 Nort | n Carolina | |
| | ehow d m | 10a. State 10b. County | 10c. City, 1 | Town or Location | | | | 10d. Inside City Limits | |
| | the Menyls 28s-f sho northed at | Maryland Prince Ge | eorge's Lan | dover | | | | 1 ② [Yes 2 □ No | |
| | A P D | 10e. Street and Number 3823 64th Avenue, | ‡2 | 10f. Zip Code 20 | 782 | 10 | U.S.A. | ntry? | |
| 020 | by | 11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced | 2. Wes Decedent Ever in U,S. Armed Forces? 1 | 13. Was Decedent of I if Yes, specify Cub 1 ☐ Yes 2 ☒ No | | ecify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 21215-0020 | within 72 ene. then 'net he test | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6th | | 16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Domestic | during most of worki | ng 1 | 66. Kind of Business/Ir | | |
| | Mental Hyginsked other artic event, I | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | (First, Middle, M | faiden Sumame) | | |
| yia | Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Me | Rufus Marable | | | Lillie | | | | |
| Maryland | ges 1 and 2 should be filed to the filed and Mental Hyg If Item 27 is marked other or other treumatic event. | 19a. tnformant's Name/Relationship (Typ Lillie R. Marable, | | 19b. Mailing Address (Street 3823 64th Ave | | | | | |
| Baltimore, | ages 1 end ant of Heelth t: If Item 27 y or other tr | 20a. Method of Disposition 1 Ki Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) | movel from State | e of Disposition (Name of betery, crematory or other pla est Hills Ceme | | 02/12 | 20c. Location - City or T | | |
| Baltir | Department of Important: If Important: If any Injury or once. | 21. Signeture of Fundral Service License | | J.B. JENKI | ess of Fecility NS FUNERA | L HOME | Clinton, Ma | | |
| | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on | ations that ceused the death. | | | | er, Marylan | Approximate | |
| | Physician /Medical Examiner | shock, or heart failure. List only one Immediate Cause (Finel disease or condition resulting in death) a. | SEPT1 | 0 | | | | Interval Between Onset and Death | |
| L | ž. | Tooling it coally | | 17hr | | | | | |
| 0, | ifficate be executed g physician end es the buriel-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events | Due to (or at | s e consequence of): | PNEUM CT IN | | | 17 hr. | |
| × 68760, | certificate be | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as | s a consequence of): | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | |
| Box | e ettendir od for use sician/A | Pert It. Other significant conditions cont | ibution to death but not resulting | ng in the underlying cause di | ven in Part I | 23h Did tol | hacco usa contributa | to the cause of death? | |
| , P.O | es that the deeth cert igned by the ettendin be deteched for use by Physician/N | D | | | | | s 2 No 3 Pro | | |
| Records, | requir sen s hould | Peripheral | scular a Vascul | ar dise | 'ase | 24a. Was ar perform | ned? | Vere autopsy findings vailable prior to ompletion of cause f death? | |
| | stelen: The lew s certificate hes b lirector, page 2 s o Be Compli | Hypertens | in | | | 1 ☐ Ye | | Yes 20M | |
| of Vital | yalclen: is certifica director, p | 25. Was case referred to medical examiner? | - | | 26. Place of Death | Check only one | 9) | | |
| 2 | > = - | 1 ☐ Yes 2 ☐ No Ho | | Vourpatient 3LI DOA | | | nce 6 Other (Spec | ity) | |
| no | After funer funer | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of tnjury (Month, Day Year) | Bb. Time of 28c. Inju Wo | | 28d. Describe no | w injury occurred | | |
| Division | tal or Attending P in effect death. at Director: After tiled in by the funera Certification: | 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State) | | | | | | | |
| _ | To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 1 | | clan: To the best of my knowle er: On the basis of examination and manner stated. | | | | | | |
| | Nethin 2 | 29b. Signature and title of certifier | WAS INSTRUCTED STRUCT. | 29c. Licens | | | d. Date signed (Month | | |
| | | Menei | | D19 | 7609 | 1 | .15.20 | 30 | |
| | | RAMAN R- TU | | 3a) (Type, Print) 1810 Darnestov | vn Road, # | 202, Ga: | ithersburg. | MD 20878 | |
| | State | 31. Date filed (Month, Day, Year) | 32. Registrar's Signatur | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death Month

1. Decedant's Nama (First, Middla, Last) **Physician** Loretto February Mattare 2,2000 /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery if Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funerai** 1□M XXF Yrs. Director 579-16-1164 96 April 12,03 Baltimore, MD Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 28a-f show maist be notified at Director Maryalnd Montgomery Chevy Chase 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 6 238 # 8101 Conn. 606 North Ave. 20815 United States death Funeral Nema 2 12. Was Decedant Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. should be filed within 72 hours effer on Mentel Hygiene.
marked other than "natural", or liter 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by 3 ₩idowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Accountant permit. Peges 1 and 2 should be file Department of Heelth end Mentel Hy Important: If Itsm 27 is marked other any Injury or other traumatic event once. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surnama) William Grayson Carrico Schneider Amanda 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number; City or Town, Stata, Zip Coda) George Brent Mickum/Grandson 8903 Kensington Pkwy, Chevy Chase, MD 20815 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Feb 2 3 Ramoval from Stata 1 ☐ Burial 2 ☑ Cramation 4 Donation wrthern Va. Crematory2000 Arlington, Virginia 21. Signatum of 22. Nama and Addrass of Facility Takoma Funeral Home 254 Carroll St. NW Matthews 23a. Part (Enfar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart tailura. List only ona causa on aach lina. **Physician** /Medicai Immediata Causa (Final disaasa or condition rasulting in daath) Arteriosclerotic Cardiovascular Disease **Examiner** Dua to (or as a consequence of): Examiner The lew requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disaase or Injury that initiated evants rasulting in death) Last and Dua to (or as a consequence ot): physician a the buriel-P.O. Box 68760. Physician/Medical Dua to (or as a consequance of): attending pl

23b. Did tobacco use contribute to the cause of death?

Part II. Other stgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

1 Yes 2 No 3 Probably 4 Unknown 24b. Wera sutopsy findings available prior to complation of causa of death? 24a. Was an autopsy parformed?

98

9:37 AM

10d. insida City Limits

Approximate Intarval Bet Onsat and Death

Years

1 ☐ Yas 2/☐No

1 Yes 2 No 1 Tyas 2 No

25. Was casa raferrad to medical 1 Yas 2 No 27. Mannar of Death 28a. Date of Injury (Month, Day Year)

26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred

5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcide 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homloida

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a, Cartifiar

157 Certifying Phystolan: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
20 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa number

29b. Signature and title of certifier

D - 32033

29d. Data signed (Month, Day, Year) February 2, 2000

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print)

Peter Hamm, MD 31. Data tilad (Month, Day, Yaar)

5454 Wisconsin Ave. Suite 1125 Chevy Chase, Md. 20815

State Registrar

signed by the a

ate has is certificate h

this funeral

After

after death Director: A

a Funeral Di Funeral Di eletely filled Ir

To the Hosp within 24 hou To the Funer completely fil

þ

Completed

Be

2

Certification:

edicai

Records,

Division of Vital

Hospital or Attending Physician:

death.



FEB # 4 2000

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Donald McFarland Leroy February 2, 2000 2:45 pm /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crescent Cities Center Riverdale Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey. Year May 30, 1 5. Social Security Number 7. Age (in vrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 479-12-6761 79 1920 Iowa Director **Uaual Residence of Decedent** the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahos 1K Yes 2 No Director Maryland Prince George's 28a-f Hvattsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 4232 Nicholson Street 20781 U.S.A. Norns 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritel Status 14. Rece - American Indian, Black White etc. filed within 72 hours after 1 X Yes 2 No If Yes, Give Yeer or Detes: 1942-45 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 ₺ No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United Mine Workers Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Supervisor Welfare & Retirement Fund permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: it flem 27 is marked other any Injury or other trassected other 900s. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Jesse P. McFarland Flossie Bonney 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4232 Nicholson Street, Hyattsville, MD 20781 Martha A. McFarland - Wife 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State ery, cremetory or other piece) 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 02/03/00 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 ean esto 23a. Part1. Enter the disease, or complications that caused the death abook, or heart failure. Lipt only one cause on each line. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Cirrhosis of Liver Examiner Due to (or as a consequence of): Examine that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician is the burief Box 68760. Physician/Medical Due to (or es a consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Diabetes Mellitus Division of Vital Records. py The law requires Completed 24e. Was an autopsy performed? 24b. Wera eutopsy tindings available prior to completion of cause of death? **page 2** 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Puneral Director: 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) FID 4 Homicide completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier within 2 To the I \$ 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 0 C D39550 February 3, 2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4850 Forbes Boulevard, Lanham, Maryland 20706 George C. Hajjar, Jr.,

Registrar **DHMH 16 Rev 6/95**

State

31. Dete filed (Month, Day, Year)

FEB 0 4 2000

32. Registrar's Signature

FEB 9 4 2000 1 Second St. American

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month WARTIN DONACI EDWARD FEBRUARY 2000 10:15 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CANHAM, MIT HOSPITAL DOETURS Prince Gearges Community If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1⊠M 2□ F 579-46-0234 Feb. 1, 1936 Washington, DC **Usual Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4709 Tuckerman Street 20737 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Yea 2 ☑ No If Yes, Give 1 Never Married 2 Merried 1□ Yes 2♥ No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Food Industry Manager 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Charles Martin Minnie Whitt 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Dennis McGuire (Nephew) 13720 89th Avenue North, Seminole, FL 33776 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02/04/00 Alexandria, Virginia 22. Name end Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 mad 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Couse (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 3 ☑ No 3 ☐ Probably 4 ☐ Unknown 01 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2/2000 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menger of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Neturat 2 Accident

Physician /Medical **Examiner**

Physician

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Department of Health of Important: If Itam 27 is any injury or other tra

burial-transit pue Box 68760, USB as 1 igned by the atte P.O. Records, certificate of Vital this funeral After Division

or Attending 24 hours after death.

Funeral Director: A Hospital within 2 \$ 0

State Registrar

29b. Signature and little of certifie

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Creen belt, MD ZOG

ted cause of death (Item 23a) (Type, Print) Greenmag Genter Drive

31. Dete filed (Month, Day, Year) FEB 0 4 2000

32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hazel Viola Monday 31, 2000 January 3:30 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3202 Kimberly Road Hyattsville Prince George's # Under 1 Year | Worder 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 577-42-9603 83 Director Sept. 8, 1916 Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show Norw 23s or 25s-f show 1 X Yes 2 No Directo Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3202 Kimberly Road U.S.A. 20781 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No ff Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11 Merital Stetus than "natural", or hen the Medical Examiner Black, White, atc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ģ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglens. Other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: if New 27 is marked other the
any Injury or other trearment. 12 Draftsman D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Nelson Garris Gertrude Garris 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Monday - Son 3202 Kimberly Road, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from Stete 02/04/2000 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery Tionesta, Pennsylvania 21. Signature of Funeral Service Libenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 TER 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallitim. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Finel Dementia 5 years disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. edical Due to (or as a consequence of): Physician/M signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PO 1 Yas 2 No 3 Probably 4 Unknown Thrive (anorexia) 10 Division of Vitai Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed page 2 a 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun 1 Yes 2 No investigation 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Feb 01, 2000 030111

Registrar

31. Data filed (Month, Day, Year)

W Junes Mi)

32. Registrar's Signatura

PO BOX 385 LayreL Md 207 25- 0385

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Physician | 1. Decedent's Name (First, Middle, Last) | | OGI | tificate of | Death | 2. Dete of Dea | Reg. No. | 3. Time of Death | | | | |
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| Physician /Medical | Ishiam John Mo | onroe | | | | JANUA | Py 28 | 2000 2:55 Al | | | | |
| Examiner | 4a Facility Name (If not institution, give a Doctors Hospital | street and number) | | | 4b. City, Town, or Lo Lanham | | Prince | George's | | | | |
| Funeral Director | 379=07=8331 | 7. Age (In y M 2□ F 86 | yrs. last birthday) Yrs. | If Under 1 Year Months Days | r If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Day July 23 | , Year) 1913 | 9. Birthplace (State or Foreig Country) St. Paul, SC | | | | |
| 100 | Usual Residence of Decedent 10a. Stete 10b. County | 100 | City, Town or Lo | cation | | | | 10d. Inside City Limits | | | | |
| 28a-f shown notified at | MD Prince Ge | | anham | | | | | 1⊠ Yes 2□No | | | | |
| at Directo | 10e. Street and Number 6602 94th Avenue | | | 10f. Zip Code | 20706 | | 10g. Citizen of W USA | That Country? | | | | |
| rai', or itema 23a or 28a-1s Examiner must be nouted I by Funeral Director | 11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Give Year or Detes: | | | Was Decedent of 1 Yes, specify Cut 1 ☐ Yes 2☑ No | Hispanic Origin? (Spe ban, Mexican, Puerto I Specify: | city Yes or No- Rican, etc.) | | - American Indian, k, White, etc. Black | | | | |
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| a marked other numatic avent, to To Be Co | 17. Father's Name (First, Middle, Last) | | 120 | ON DIIVE | 18. Mother's Neme | (First, Middle, | | | | | | |
| o Bo | John Monroe | | | | Mary R: | | | | | | | |
| raumatic avent, the It | 19e. Informent'a Neme/Reletionship (Ty | rpe, Print) | 19b. Meilir | ng Address (Stree | at and Number or Rura | | er, City or Town, | State, Zip Code) | | | | |
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| Important: If item any injury or othe once. | 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify) | emover from State | | sition (Neme of netory or other pla Memori | al Park 2, | Date /05/2000 | | city or Town, State | | | | |
| attending physician and for use as the burial-frames to burial-frames claryMedical Examiner | 23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | Due to | o (or as a consequence of consequence) | 719 Kenner the mode of dy | the s | t, NW respiratory are | Wash., I | Approximate Interval Between Onset end Death Mon //a | | | | |
| by the tached thysi | Part II. Other significant conditions con | COLUMN STREET, SOUTH | resulting In the ur | nderlying cause gi | iven in Pert I. | | obacco use con Yes 2 No | itribute to the cause of death | | | | |
| page 2 should be det Completed by Pl | - Hype sta | ensie | | | | 24a. Wes | an autopsy | 24b. Were autopsy findings available prior to completion of cause of death? | | | | |
| Cor | | | | | | 101 | es 20 No | 1 Yes 2 No | | | | |
| Be Be | 25. Was case referred to medical examiner? | lospital: | | 10 | 26. Place of Deeth | (Check only o | ne) | | | | | |
| ad in by the funeral din certification: To | 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Dete of Injury (Month, Dey Year | 2 ER/Outpatien 28b. Time of Injury | 28c. Inju | 4 LI Nursing Hor | | lence 8 □Othe low injury occurr | | | | | |
| S y to | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - A building, etc. (Spe | t home, ferm, str | eel, fectory, office | | 281. Location (5 City or Tox | tion (Street end Number or Rural Route Number, or Town, State) | | | | | |
| din b | | | | | | | | | | | | |
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| npletsly fill | (Check only 2 Medical Examin | and manner steted. | 1 | 29c. Licen | nse number | | 29d. Dete signed | (Month, Day, Year) | | | | |
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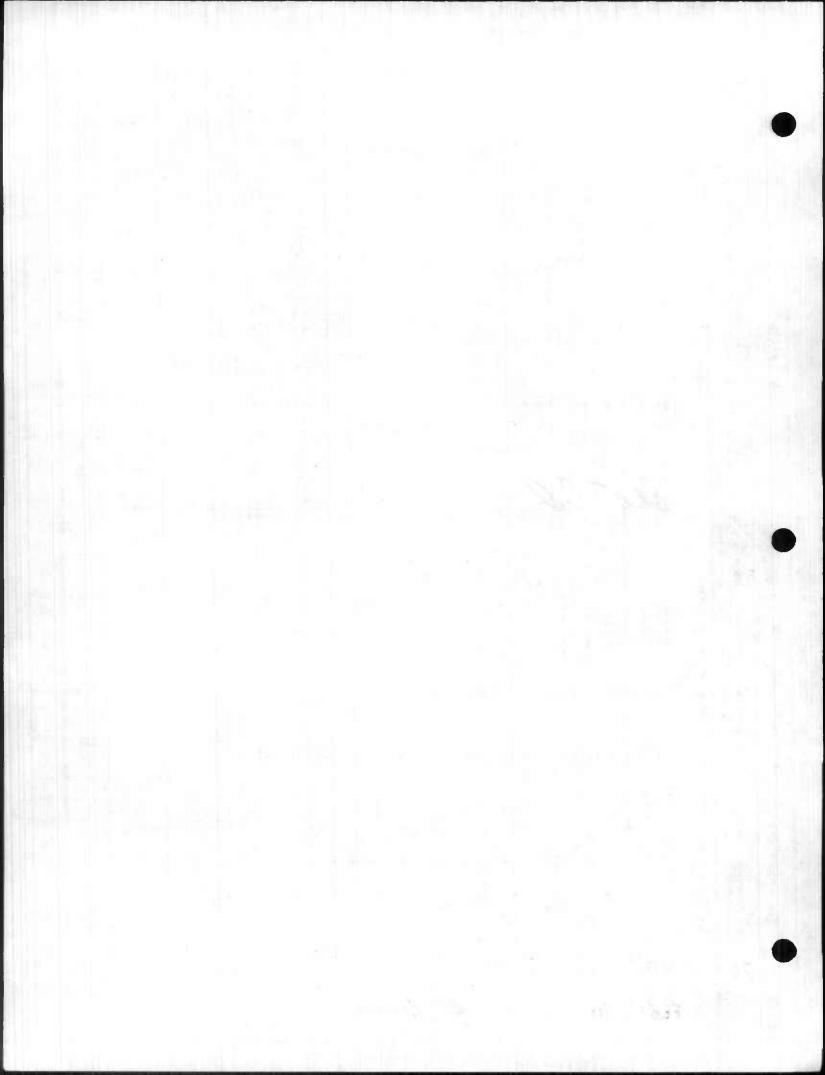
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State of Maryland / Department of Health and Mental Hygiene

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| illei | Union | Hospital | l of | Cacil | Count | - 37 | | | , | Elkto | n | | C | ecil | | | |
| | 5. Social Secu | | 6. Sex | | 7. Age (In y | - | | Under 1 | Yaar | If Under | 24 Hrs. | 8. Data of B | irth | | 9. Birth | place (State | or Foreign |
| l r | | 6-4098 | |]M 2∭ F | 77 | | rs. Mo | onths | Days | Hours | Min. | (Month, D August | lay, Year, | 022 | Cou | York | |
| | | ice of Decedeni | | | - / / | | | | | | | nuguse | J, 1 | 1 4- 4- | MEM | IUIK | |
| | 10a. Stata | 10b. County | , | | 10c. | City, Town | or Locatio | on | | | | | | | | 10d. Inside C | ity Limits |
| ō | D | . D | h 1 1 . | adelph: | in D | | 1.1. | | | | | | | | | 1 Yes | 2□No |
| Directo | Pennsyl | 7 4472 | пттс | auerpii. | Ia P | hilad | | 1.a Of. Zip C | `ada | | | | 10a C | itizen of V | Mark Cou | -1-2 | |
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| Funeral | | yson Aver | | | | | _ | 1914 | | | | | - | ted S | | | |
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| Dy F | | Married 2 Marr | | 1 ☐ Yes If Yas, Gir | 2 No va | | 101 | Yes 25 | ⊠ No | Specify: | | | | Specify | , | | |
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| ž | | 15. Decedan Specify only higher | t's Educ | cation | | 16a. l | Decedent's | s Usuel | Occupi done o | ation during mos | t of work | ina | 16b. F | Kind of Bu | siness/Ir | ndustry | |
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| 900 | 17. Fathar's No | ema (First, Middle, | Last) | | | 363 | | | | 18. Moth | ar's Nema | a (First, Middl | e, Maider | n Sumam | 10) | | |
| 2 | Max Ki | rschner | | | | | | | | Mo11 | ie R | osenbe | ro | | | | |
| | | t's Name/Ralations | ship (Ty | pe, Print) | | 19b. | Mailing Ad | ddress (| Street | | | al Route Num | | or Town. | State, Zi | p Code) | |
| | Dobont | A. McKir | | 1 500 | | | | | | | | | | | | | |
| | 20a. Mathod o | | 111011 | / Son | | . Place of I | | | | urive | <u> 1</u> | kton, | | | | own, Stata | |
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| | 4 Donat | ion 5 Othar (S | ipecity) | | Wh | itema | irsh l | Memo | ria | 1 Par | ck 8 | , 2000 | Aml | bler | , Pei | nnsylv | ania |
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| | 1/10 | B 1.1. | | | | | | | | neral | | | 1 | | 26 | | 0100 |
| | 23a, Part1, Er | nier lhe disease, or | r comoli | ications that c | aused the de | oth Doo | 112/ | Sout | CII I | Main | Stre | et, No | run | east. | , Ma | ryland | 2190 |
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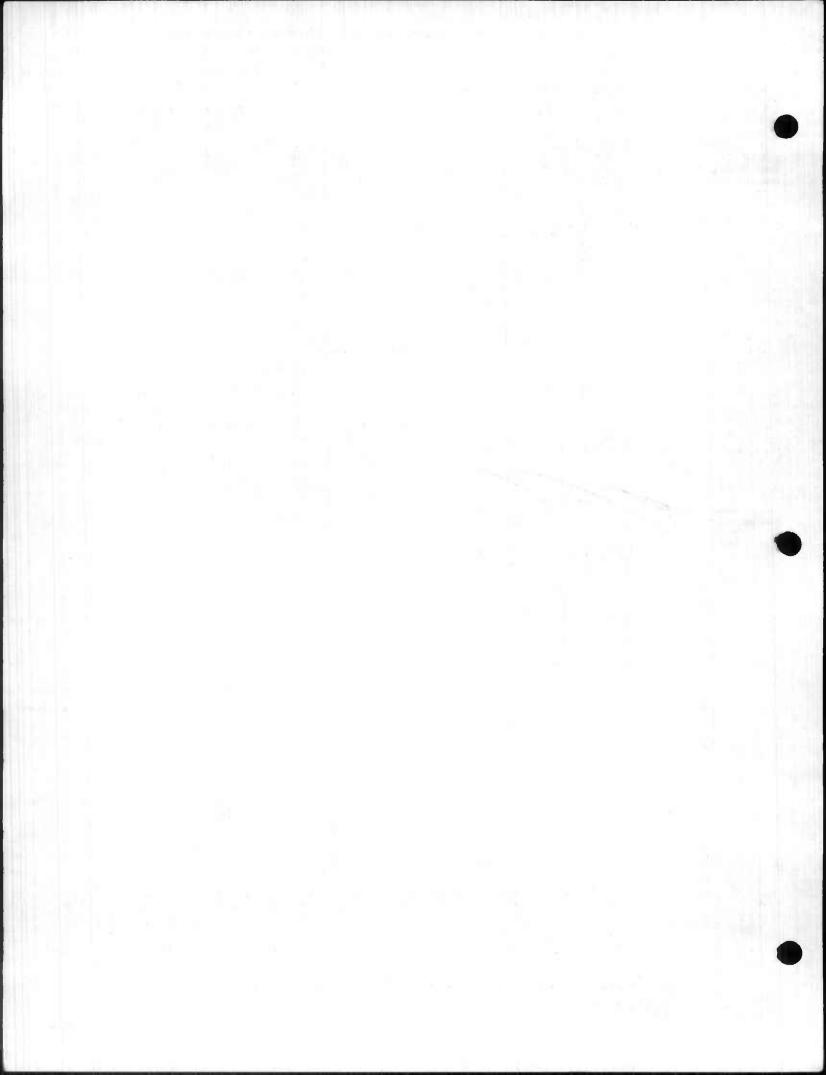
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State of Maryland / Department of Health and Mental Hygiene 0 5204

| | | | | | | Certific | cate of | Death | | Re | g. No. | O (| J & () | 7 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------|----------------------|---------------------------|------------------------------------|--------------|----------------------------------------|------------------------|---------------------------|-------------------------------------------------------------|------------|
| П | Division | | 1. Decedent's Name (First, Middle, Last) |) | | | | | | Date of Deat | h | Vers | 3. Time o | of Death |
| | Physic /Medi | | Luther Hanson McG | Blothlin | | | | | | Month Garage | Day | Year Logu | 23 | 59 |
| | Exami | | 4a. Facility Name (If not institution, give | street and number) | | | | 4b. City, Town | | | 4c. County | of Death | | |
| | | | 44 McGlothlin Rd. | | | | | Conow | | | Cec | il | | |
| | Funeral Director | | 5. Social Security Number 6. Sep 215-42-7507 Usual Residence of Decedent | y 7. Age (h | yrs. last bir | | Inder 1 Year ntha Days | | Min. | Date of Birth Month, Day, Ct. 1, | Year) 1944 | 9. Birthp Coun Mart | place (State of htry) Lyland | or Foreign |
| | show | | 10a. State 10b. County | 10 | c. City, Town | n or Location | n | | | | | 1 | 0d. Inside C | |
| | Ne M | Director | Maryland Cecil | | Cono | wingo | | | | | | | 1 LI Yes | 2 🔯 No |
| | 3a or 3 | ai Dir | 10e. Street and Number 44 McGlothlin Rd. | | | 10 | of. Zip Code | 918 | | 10 | og. Citizen of V | What Coun | try? | |
| | deat deat | Funeral | | 12. Was Decedent Ever Armed Forces? | r In U,S. | 13. Was [| | Hispanic Origin pen, Mexicen, F | ? (Specify | Yes or No- | 14. Rac | e - Americ | | |
| Maryland 21215-0020 | filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28e-1 show ent, the Medical Examiner must be notified at | by | 1 ☑ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | | | | Specify: | чепо ніса | n, etc.) | Specify | white, | | |
| 5-0 | 72 ho | Completed | 15. Decedent's Educ (Specify only highest grade | cetion | 16a. | Decedent's | Usual Occu | pation during most o | functing | 1 | 16b. Kind of Bu | | | |
| 121 | ithin ne. | nple | Elementery/Secondary (0-12) | College (1-4or 5+) | | life. DO NO | OT use retire | 9d) | WOIKEIG | | | | | |
| 12 | e filed within at Hygiene. other than 'vent, tre Me | | 9 17. Father's Name (First, Middle, Last) | | | Junk | Deale | | | | Junk | | | |
| and | d la b y | Be | | 0: | | | | | | | fa <i>iden Suma</i> m | | | |
| IZ | d 2 should by th and Menta T is marked traumatic sy | J. | Luther J. McGloth 19e. Informant's Neme/Relationship (Ty) | | 195 | Mailing Add | drace /Strac | t and Number | | | rtridge | | Codel | |
| | d 2 s | | Tina Pennell | po, 7 mil) | - | | | in Rd. | | | | | C000) | |
| re, | _ = = = | | 20a. Method of Disposition | | Ob. Place of | Disposition | | | | | 20c. Location - | | wn, Stete | |
| Baltimore, | permit. Peges 1 Department of H Important: If its any injury or of once. | 1 3 | 1 🕅 Burial 2 🗖 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | _ | | ony Ch | apel | Cemeter | | | | ngo, | Maryl | land |
| Ba | Depa Impo any il | | 21. Signature of Funeral Service Liceoe | | | | | ess of Facility d Fune | | | | 21011 | | |
| | | | 23a art1. Enter the disease, or comparation of heart failure. List only on | cations that caused the | death. Do n | ot enter the | mode of dy | ing, such as ca | rdiac or res | piratory arre | st. | 1711 | Approximat Interval Bet | te |
| ą, | Physician | | | | | | | | | | | 1 | Onset and | |
| | /Medical Examiner | | ffirmediate Cause (Final disease or condition resulting in death) a | 150 | UD | | | | | | | | near | 5 |
| | | | resulting in dealth | Due | to (or as a c | onsequence | e of): | | | | | | | |
| Т | fled net | Ë | ~ 1 | | | | | | | | | | | |
| ď, | ficate be execute physician and is the builal-trans | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due | to (or as a c | onsequence | a of): | | | | | | | |
| 68760, | e par | edical | that initiated events | Due | to (or as a o | onsaguanne | offic | | | | | - | | |
| | erificate be ling physica e as the bu | Med | resulting in death) Last | | | | - | | | | | | | |
| Box | 0 2 2 | | - d | | | | | | | | | - | | |
| | the atternment for s | Physician | Part II. Other eignificant conditions con- | tributing to death but no | ot resulting In | the underly | ring ceuse gi | ven in Pert I. | | 23b. Did tot | bacco use cor | ntribule to | the cause | of death? |
| , P.O | that the ed by detac | by Phy | | | | | | | | 1 🗆 Ye | a 2 No | 3 Prob | oably 4 | Unknown |
| Records | aw requi | Completed t | | | | | | | | 24a. Was ar perform | | ava | ere autopsy i milable prior t mpletion of d deeth? | to |
| E | 0 - 0 | E O | | | | | | | | 1 🗌 Ye | s 20(No | 1[| Yes 2 |] No |
| Vital | ysician: The s certificate director, pag | Be (| 25. Wes case referred to medical examiner? | | | | | 26. Plece of | Death (Ch | eck only one | 9) | l | | |
| J o | Physician: this certific ral director, | ျှ | 1 Yes 2□ No H | ospital: | 2□ ER/Out | patient 3 | 1 DOA | | ng Home | 5 Resider | nce 6 DOth | er (Specify | 0 | |
| | ding P th. After t | tlon: | 27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation | 28e. Dete of Injury (Month, Day Ye. | 28b. T | lme of njury M | 28c. Inju Wo | ryat ork?]Yes 2 ⊡ No | 28d. | Describe ho | w injury occurr | ed | | |
| Division | To the Hospital or Attanding I within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funer | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - building, etc. (S | At home, fair pecify) | m, street, fa | | | 28f. I | ocation (Str. City or Town, | eet and Numb State) | er or Rura | Route Num | nber, |
| | the Hospital hin 24 hours the Funeral I npletely filled | edical (| 29a. Certifier (Check only one) | ician: To the best of my er: On the basis of exa and manner stated. | and an address of the same of | 111 | - Al 1 - · · | 1 . 1 | 1 . | 41 41 1 | | | | s) |
| | To the Within To the compl | Me | 29b. Signature and title of certifier | / | | | 29c. Licen | se number | | 29 | d. Date signed | (Month, L | Day, Year) | |
| | . WA | | > It fork | and manner stated. mpleted ceuse of deeth 32. Registrar's S | | | 21 | 531 | 4 | 1 | -e brua | 442 | 200 | 00 |
| | ++11 | | 30. Name and address of person who cor | mpleted ceuse of deeth | (Item 23a) (| Type, Print) | 1 | 1 4 | | | | 1 | 1 | - |
| | | | 31. Date filed (Month, Day, Year) | 2 Unio | n Hos | pital | ELA | (10n, 1 | دوس | 1921 | | | | |
| | Sta | te | FEB 0 3 2000 | 22. riegistrar's | Signature 4 | las | 1 | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month Day Year 2050 Boyd John Michael, Jr. February 2000 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Hagerstown Washington County Hospital Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Year) March 7, 9. Birthplace (State or Foreign Country) Waryland 5. Social Security Number 7. Age (In yrs. last birthday) Days 1DXM 2DF 70 Yrs. 217-28-5811 1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Washington Boonsboro Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9102 Mapleville Road 21713 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 DX'es 2 □ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2X Merried 1 Yes 2 XNo Specify: Specity: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) teacher/administrator county government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Boyd John Michael, Sr. Nellie Marie Clopper 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian S. Michael - wife 9102 Mapleville Rd., Boonsboro, Md. 21713 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, Slata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Cedar Lawn Mem. Park 2-5-00 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Causa (Finel 1-2 days Phenonia disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did lobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician and for use as the burial-transit

signed by d

certificate

To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director; After th completaly filled in by the funeral

Director: After

Division of Vitai

Completed

Be

Certification:

Medical

Physician

/Medical

Examiner

Directo

Funeral

à

Completed

Be

Funeral

Director

r than "natural", or hams 23s or 25s-f the Medical Examiner must be notifie

filled within 72 hours after Hygiene. Wher then "netural", or he

permit. Pages 1 and 2 should be filled in Department of Health and Mental Hyglen Important: if New 27 is marked other the any Injury or other traumetic.

Maryland 21215-0020

Baltimore,

nichael, 150y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical à

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Holmknown Dystasia, memia Partinai Dinen: 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Wes case referred to medicat 26. Place of Deeth (Check only one)

Hospitel: 1 ☐ Inpatient 2 ☐ ET/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Divatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29c. License number

-tout mo

D18019

29d. Date signed (Month, Day, Year) FEB 2, 2000

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 0 4 2000 32. Registrar's Signeture Gener



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

If Under 1 Year

10f. Zip Code

Car Inspector

21742

1 ☐ Yes 2 ☑ No Specify:

16a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired)

pullemone

Months |

Deys

7. Age (In yrs. last birthday)

75 Yrs.

10c. City, Town or Location

Hagerstown

State of Maryland / Department of Health and Mental Hygiene 05206. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Date of Death Month Day Year Ray Howard McAllister February 1,2000 11:25

Physician /Medical Examiner

4e Facility Neme (If not institution, give street end number) Washington County Hospital

10b. County

12 M 2□ F

5. Social Security Number

10a. Stete

214-28-0774

Usual Residence of Decedent

4b. City, Town, or Location of Death Hagerstown

8. Dete of Birth (Month, Day, Year) May 12, 1924

18. Mother's Name (First, Middle, Maiden Sumeme)

Edna Ellen Hawbaker

22120 Pikeside Drive, Smithsburg, Maryland 21783

Date

22. Name and Address of Fecility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 21742

Feb. 4

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

4c. County of Death Washington County

10g. Citizen of What Country?

16b. Kind of Business/Industry

Railroad

20c. Location - City or Town, State

Hagerstown, Maryland

Approximete Intervel Betw Onset and Death

U.S.A.

14. Race - American Indian,

White

Black, Whita, etc.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

Funeral

Director

28a-1 herra 23a or munt be "natural", or

Hygiene. permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important: If New 27 is marked other any Injury or other.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

and signed by certificate Division of Vital this After or Attending death. To the Hospital of within 24 hours a To the Funeral D

Howard

Ray

RACAIlister,

Examiner Physician/Medical by Completed Be P Certification: 29e. Certifier Medical

MD Washington Co. Director 10e. Street and Number Funeral t 1. Meritel Status À Completed 6 Be Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical 2 ☐ Accident 3 Suicide 4 T Homicide

14014 Marsh Pike 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Howard McAllister 19e. Informent's Neme/Reletionship (Type, Print) Michael Ray McAllister/Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1⊠Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Rest Haven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service License 23a. Pert f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. conviction Due to (or es e consequence of): hagia Due to or es a consequence of):

Due to (or es a consequence of): Part If. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1⊠Yes 2□ No 3□ Probably 4□ Unknown

ZZ No

24a. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

| 1 Yes 2 No | Hospitel: 1 Inpatient 2 | ☐ ER/Outpatient | 3□ DOA |
|---------------------|------------------------------------------|---------------------|--------|
| 27. Menner of Death | 28e. Dete of fnjury (Month, Day Year) | 28b. Time of fnjury | 28c. |

28e. Dete of fnjury (Month, Day Year) investigation 6 Could not be determined

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

1 Yes 2 No 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

(Check only one) 29b. Signeture end title of certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Keedysmile, md. 21756

D325/8

28c. Injury at Work?

2.300

State Registrar

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

00

DHMH 16 Ray 6/95

Michael Ray McAllist

x

Add O Jimme

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | State of Maryland / Department of Certificate of | | | giene Reg. No. | 0 0 | 5207 |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------|--------------------------------------|----------------------------------|-------------------------------------------------------------|
| ľ | | 7 | Decedant's Neme (First, Middle, Last) | - | 2. Data of De | | | 3. Tima of Death |
| , | Physicia /Medic | | Kenneth Albert Myers | | Januar | 4 | Year 000 | 8:37 pm |
| | Examin | er | 4a. Facility Name (If not Institution, giva street end number) | 4b. City, Town, or L. | | 7 | | |
| _ | | ш | Williamsport Nursing Home | | msport | | ashing [.] | |
| | Funeral Director | | 5. Social Security Number 215-09-7320 6. Sex 120M 2 F 7. Age (In yrs. last birthdey) 88 Yrs. 6. Months Days | | 8. Deta of Bir (Month, Da Aug. 12 | th ly, Year) ?,1911 | 9. Birthplec Country) Mary | a (Stete or Foreign land |
| | and * | | Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location | | | | 10d | inside City Limits |
| | Aaryte f eho | o | | | | | | 1 Yes 2 XNo |
| | the f | Director | Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code | <u> </u> | | 10g. Citizen of V | What Country | 7 |
| | 3a or | Ö | | 1705 | | | | • |
| | deeth ms 2 | Funeral | 11 Marital Status 12 Was Dacedant Ever in U.S. 13 Was Decedant of | 1795 Hispenic Origin? (Sp | ecify Yes or No | | JSA e - American | Indian, |
| 750 | s 1 and 2 should be filed within 72 hours efter deeth with the Maryland I Heelth end Mental hygiene. Item 27 Is marked other than "naturel", or items 23s or 28s-f ehow other traumatic event, the Medical Exercites must be notified at | by Fur | Armed Forces? If Yes, specify Cul 1 Never Merried 2 Married 1 Yes, 2 No 1 Yes, Give 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No | ben, Mexican, Puarto Specify: | Rican, atc.) | Specify Specify | White, atc. | |
| 5 | 2 hou | | 15. Decedent's Education 16a. Decedent's Usuel Occu | upetion | | 16b. Kind of Bu | | |
| 1712 | 2 should be filed within 7 end Mental Hygiene. Is marked other than "n. surnatic event, the Medi- | Completed | (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Minist | | ing | | Church | |
| 2 | Hyg other | Be C | 17. Father's Name (First, Middle, Last) | 18. Mother's Nem | e (First, Middle | | | |
| 0 | Aenta Aenta rked ric ev | To B | Robert Lincoln Myers | Ida Ma | e Davis | | | |
| a | shot shot | - | 19e. informent's Name/Reletionship (Type, Print) 19b. Melling Address (Stree | | | | Stete, Zip Co | ode) |
| 7 | er tra | | Juanita Palmer/Daughter 118 Broadway | / Apt. #1 | Hagerst | own,MD | 21740 | |
| 5 | of He | | 20e. Method of Disposition 1 □XBuriet 2 □ Cremation 3 □ Removel from Stete | ece) | Dete | 20c. Location - | City or Town | , State |
| | meni ant: l | | 4 Donation 5 Other (Specify) Green lawn Memori | ial Park 2 | -4-00 | Williams | sport, | Maryland |
| 20 | permit. Peges 1 and 2 Department of Heelth e important: If fem 27 is any injury or other tra | | 21. Signature of Funerat Servica Liberase 22. Nama and Add USDOPNE | uneral Ho | me. P.A | | | |
| | 0.0 E a d | | | onococheag | | | sport, | MD 21795 |
| | Physician | | 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one ceuse on each line. | ring, such es cardiec | or raspiratory a | rrest, | int | oproximate tervat Between nset and Death |
| 1 | /Medical | | Immediate Cause (Finel disease or condition resulting in death) a. Cerebral Inforct | | | | Ye | 215 |
| | Examiner | _ | resulting in deeth) Due to (or es e consequence of): | | | | | |
| _ | bei isi | Examiner | b. loysphagia | | | | 1 | |
| 2 | end el-trar | xan | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underfying Cause (Disease or Injury | () | | | | |
| 2 | eath centificate be executed ettending physician end for use es the buriel-transit | edicai E | | Iration | | | We | eks |
| 5 | g phy g phy es the | | resulting in deeth) Lest Due to (or es a consequence of): | | | | 1 | |
| 5 | andin use | lan/M | d | | | | | |
| | deat de ett | sicia | Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause of | iven in Pert I. | 23b. Did | tobacco usa con | ntributs to th | e cause of death? |
| | res the the de signed by the e be detached | Physic | | | 10 | Yss 2 No | 3 Probab | oly 4 🗆 Unknown |
| 5 | igned be d | by | | | | | T | |
| | bluods | Completed | | | 24e. Wes | an autopsy ormed? | evalle | autopsy findings ble prior to letion of cause eth? |
| | 0 - 2 | E O | | | 10 | Yes 2 No | 1 🗆 Y | es 2□ No |
| | ysician: The | Bec | 25. Wes case referred to medical exeminer? | 26. Plece of Deel | h (Check only | one) | | |
| | Physician: r this certific rral director, | 10 | 1 ☐ Yes 200 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA | | ome 5 🗆 Resi | denca 6 🗆 Oth | er (Specify) | |
| | g ge | ion: | 27. Manner of Death 1 Naturel 5 Pending (Month, Dey Year) 28b. Time of Injury 28c. Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury | | 28d. Describe | how injury occurr | ed | |
| 2 | Attending or death. ector: After by the fune | fical | 2 Suident 6 Could not be | Yes 2 No | 28f Location / | Street end Numb | er or Rural R | oute Number |
| | al or A | Certification: | 4 Homtolde determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | * | City or To | wn, State) | D7 07 1 107 21 1 1 | oute i voiriour, |
| | To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the to | edicai (| 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the to 2 Medical Examiner: On the basis of examinetion end/or investigation, in my end menner stated. | ime, dete and plece, opinion, deeth occur | and due to the red et the time, | cause(s) and ma dete end plece, a | nner as state and due to the | d. e cause(s) |
| | within To the comp | Me | 29b. Signetura and title of cartifley 29c. Licar | nse number | | 29d. Date signed | i (Month, Da) | v, Year) |
| | | |) 1000me D33 | 700 | | Februar | u 1 | 7.000 |
| | | | 30. Name end eddress of pereon who completed cause of deeth (Item 23a) (Type, Print) | | | | | |
| | | | Ted Howe, m.D. 7542 Overlook Dr. | Boons | boro. | mp | 2171 | 3 |
| | Stat Registra | | 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture | V. 1 | , | | | |
| | 11091011 | | FEB 0 2 2000 Service 19. Span | w | | | | |

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 05208

| | Certificate of Dea | ath R | eg. No. | 1200 | |
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| | Decedent's Name (First, Middle, Last) | 2. Date of Deat Month | | 3. Time of Death | |
| Physicia /Medic | | JAN. | 17 2000 | 9:20 am | |
| Examine | As Franks Name (March 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 | ty, Town, or Location of Death | 4c. County of Death | 9:20 am | |
| | FAIRFIELD NURSING HOME CRO | WNSVILLE | ANNE ARUN | IDEL. | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U | Inder 24 Hrs. 8. Date of Birth (Month, Day, | | ce (State or Foreign | |
| Director | 465-32-4683 1□ M 2風F 89 Yrs. Months Days Ho Usual Residence of Decedent | FEB. 28 | | | |
| Now M | 10a. State 10b. County 10c. City, Town or Location | | 100 | d. Inside City Limits | |
| the Maryla 25a-f show Dolffied at | MARYLAND ANNE ARUNDEL ANNAPOLIS | | | 1 XYes 2 No | |
| 0 28 DO | 10e. Street and Number 10f. Zip Code | 1 | 0g. Citizen of What Countr | y? | |
| | | | USA | | |
| Can dear | | ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) | 14. Race - American | | |
| M | 3 XXVidowed 4 □ Divorced If Yes, Give 1 □ Yes 2 1 No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No S | | Specify: BLAC | | |
| 72 ho | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 0 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) BAKER | | 16b. Kind of Business/Indu | stry | |
| veithin 7 | (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) | most of working | | | |
| Para di | 12th 0 BAKER | F | RESTAURANT | | |
| D STATE | 17. Father's Name (First, Middle, Last) | Mother's Name (First, Middle, M | | | |
| To de de de de de de de de de de de de de | | LUCY KENNON | J | | |
| S S S S S S S S S S S S S S S S S S S | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N | | | Code) | |
| C TO 24 L | DOROTHY BENSON (DAUGHTER) 506 ROYAL ST. | | MD. 21401 | | |
| 5 - F # # | 20a, Method of Disposition 20b. Place of Disposition (Name of | | 20c. Location - City or Tow | n, Stata | |
| Baltimore, amil. Pages 1 ar apportant: if Item my Injury or other ms. | 1 A Burial 2 Cremation 3 Removal Irom State | TEMPON 1 /21 / | 2000 3 3 3 7 7 7 7 | TIC MD | |
| E delle | 4 Donation 5 Other (Specify) HILL CREST CEM 21. Signature of Funeral Service Licensee 22. Name and Address of F | | ZUUU ANNAPC | TIS, MD. | |
| B Populario | | SONS MORTUA | ARY, P.A. | | |
| | 821 WEST ST | . ANNAPOLIS | MD. 21401 | | |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. | ch as cardiac or respiratory arm | est, | Approximata ntervet Between | |
| Physician | 0 | | | Onset and Death | |
| /Medical Examiner | Immediate Cause (Final disease or condition | | BURAL | | |
| | resulting in death) Due to (or as a consequence of): | | | July | |
| 70 # . | | | | | |
| death certificate be executed extending physician and of or use as the buriel-transit | b. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying | | | | |
| 0 4 1 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | |
| 68760, ficate be ex physician | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | |
| | | | t i | | |
| BOX eath cert attendin for use | d | | 1 | | |
| D to the D | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I | Part t. 23b. Did to | bacco use contribute to t | he cause of death? | |
| o the | 2114 2 + | 1 D Y | | bly 4 Unknown | |
| | Dehydration, Dementia | | 1710 | ., ., ., | |
| Hecords, P.O. he law requires that the de a has been signed by the sge 2 should be deteched | | 24a. Was a | | autopsy lindings | |
| 0 5 6 6 | | perform | com | able prior to pletion of cause | |
| has b | | | | eath? | |
| = = = = (| | 1 🗆 Ye | es 208 No 1 🗆 | Yes 20 No | |
| 5 6 6 6 | examiner? Hospital: | Place of Death (Check only on | | | |
| 0 4 5 7 | 1 Inpatient 2 ER/Outpatient 3 DOA 4 | Nursing Home 5 Reside | | | |
| The man | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? | | ow injury occurred | | |
| DIVISION OF Lea or Attending Phy rs after death. el Director: After this led in by the funeral of | 2 Accident investigation M 1 Yes 3 Suicide 6 Could not be | | | | |
| DIVISION OF Attend after death Director: / | 3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) | 28f. Location (St City or Town | reet and Number or Rural in, State) | Route Number, | |
| D PER DE | | | | | |
| lospi I hou uner uner | 29a. Certifier (Check only Medical Examiner: On the basis of examinetion and/or investigation, in my opinion and manner stated. | ile and place, and due to the cr | ause(s) and manner as sta | ted. | |
| DIVIS To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the | and manner stated. | , was own on at the time, O | and place, and due to t | causa(s) | |
| To To the to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the total to the t | 29c. License num | | 9d. Date signed (Month, Do | ay, Year) | |
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| State | | 1 ANA II I | J. J. Wary Un. | | |
| Renistra | 14 M 0 4 2000 have | , | | | |

DHMH 16 Rev 6/95

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year January 21 2000 **Physician** Anne Mclane 4:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Say 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF 198-03-1853 80 Director Nov 8, 1919 Pennsylvania Usuai Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD Director Baltimore Parkville 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b ns 23a or must be 21234 8810 Walther Blvd. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, Whita, etc. 72 hours after 1 ZYes 2 No 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: White Specify À 3 Widowed 4 Divorced Year or Dates WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Anne Arundel County Librarian County Government 5+ Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Edward A. Hughes Mary Doris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) £ nt of Health a If Item 27 is or other tra 1623 Third Ave. Apt. 216, New York, NY 10128 John McLane/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Jan 24 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Metro Crematory 2000 21. Albhature of Fuheral Service Lice 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severna Park, MD 21146 Approximate Interval Between Onset and Death Physician /Medical Immediata Cause (Finai Chronic Obstructive Pulmonary Disease 40 years disaase or condition resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of) Box 68760. Physician/Medical the Due to (or as a consequence of): 98 980 signed by the at 1 be detached for 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records. þ The law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outputient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Pending investigation efter death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours Hospital 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) within 2 To the 5 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 20303 January 21, 2000 araw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) who completed cause of death (Nem 23a) (Type, Print)

Johns Hopkins Bayview Medical Center 4940 Eastern Avenue Baltimore, MD
21224 Param bedhig

DHMH 16 Ray 6/95

State

Registrar

31. Data filed (Month, Day, Year)

JAN 2 7 2000

32. Registrar's Signature

onne y & wall

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05210. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year JANUARY 6.31 Am CLARA E. MEDLEY 22 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE BURNIE HRUNDEL ARUNDEL HOSTITAL GLEN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Hours Months Days 1□M 200 F Yrs. 212-56-3251 FEB 68 16 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MARYLAND ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1765 CIRCLE ROAD 21144 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes XXNo 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK 3DWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE NONE 7th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) PHILLIP BUTLER CLARA PETERS 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROBERT MEDLEY (SON) 7810 CLARK RD. JESSUP, MD. 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Sporial 2 ☐ Cremation 3 ☐ Removal from State 1/27/2000 DAVIDSONVILLE, MD LAKEMONT CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Larry &, 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, finterval Between Onset and Death Deese Immediate Cause (Final BREAST CANCER 24EARS disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Baud Pressure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

The law requires that the death certificate be executed

certificate

this

Affer

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

completely filled in by

P.O. Box 68760.

Records,

of Vital

Division

or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

show

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|tems

Director

Funeral

p

Be Completed

the Maryland

filed within 72 hours after

Demit. Pages 1 and 2 should be file.
Department of Health and Mental Hygi important: if item 27 is marked any injury or other.

Maryland 21215-0020

MEDLEY,

Examiner the 080 8 Medical Certification: To funeral the

Physician/Medical 2 Be Completed

25. Was cese referred to medical 1 Yes 2 Ho

27. Mannes of Death 1 PNetural 5 Panding investigation 2 Accident 3 Suicide 4 ☐ Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28t. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Mhe

29a. Certifier (Check only one)

> HOUSE STAPE

29c. License number 52035 29d. Date signed (Month, Day, Year) 22,2000 January

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) HUSPITAL DRIVE CHACKO 301

21061

State Registrar



JAN 27 2000 passer D. Hereby

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Lillie E. Miller January 27, 2000 6:35 pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel Futurecare Chesapeake Healthcare Arnold If Under 24 Hrs. Hours Min. If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State of Country) Aug 25, 1899 Tennessee 5. Sociel Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 XF 101 402-14-6795 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County Arnold 1 ☐ Yes 2 No Anne Arundel rns 23a or 28a-f s croust be notified MD Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 329 Clifton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried b 1 Yes 2 No Specify: White Specify: þ 3 ⊠ Widowed 4 □ Divorced "natural". Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiena. ther than Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: if Item 27 is mericed or William Pinkley Edwards Julia Ann Jones 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 329 Clifton Avenue, Arnold, MD Wadie Brandimore/daughter 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Feb 2 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 Removel from State b Murray, KY 4 ☐ Donetion 5 ☐ Other (Specify) Murray City Cemetery 2000 21. Signature of Funeral Service Conseq Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 e, of cooplications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only one cause on each line. Approximate Interval Between Onset and Deeth Physician eart failure Immediate Cause (Final disease or condition resulting in death) /Medical weeks Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): and physician Physician/Medical 9 Due to (or as e consequence of) 955 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown eoporosis À chronic obstructive pulmonary 24b. Wera autopsy findings available prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed disease 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 25 No ä 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Attending Natural 2 Accident 5 Pending il or Attendin after death. Director: Aft 1 ☐ Yes investigation ⊕ □ Could not be 3[] Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital TSE Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) end menner stated. 29e. Certifier Medical (Check only Within 2 To the F å 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) FEB 0 2 2000

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

479 MD 32. Registrer's Signeture

1-28-2000

Severna Park Maryland 21146

0

Maryland 21215-0020

Baltimore,

Box 68760

P.O.

Division of Vital Records,

B. Louis

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11:29 pin **Physician** tathleen Moore JAN 25 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Clinton If Under 24 Hrs. Southern Maryland Hospital Center Prince Georges

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1□ M 2□,F Months Days Hours 51 Director 175-38-6545 Phila. Feb. 28, 1948 Pa Usuat Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Charles Director r 28a-f LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 1029 Wales Dr. 20646 U.S.A. 14. Race - American Indian, Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Detes: 11 Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Budget Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Umberto Baioni Florence Kelly 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) of Health a vit: if them 27 is view of William Moore/ Spouse 1029 Wales Dr. LaPlata, Md. 20646 20b. Ptece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Department of important: If any injury or other 1/31/2000 Lansdale, Pa. Lansdale Crematorium 21. Signature of Funerel Service Lie Asee 22. Name and Address of Facility Lee Funeral Home, INC. 23e. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Md 20735 Approximate Interval Between Onset and Death Clinton, **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 5 days Parto immune Hemple his Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760. Physician/Medical the Due to (or es a consequence of): for use 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records. P.O. 1 Yas 2 No 3 Probably 4 Unknown by 500 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 (X Neture) after death. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office bullding, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier Medical completely (Check only one) within 2 To the \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 0 D14350 26/2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8916 Woody and Road State 201 Clinton, 4820725 Car 31. Dete filed (Month, Dey, Year)
FEB 0 1 2000 . Registrar's Signeture State Registrar

DHMH 16 Ray 6/95

9899 1 0 634

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jean January
4b. City, Town, or Location of Death 26, 2000 4c. County of Death Emma Mangum /Medical 9:00AM 4a Facility Neme (If not institution, give street and number) Examiner 4913 Heath Street Hillside Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 12,1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2₽F Months Days Hours Min West Virginia 235-30-7761 75 Yrs. **Director** Usuel Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if Hem 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic avent, the Medical Examiner man be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Prince George's Hillside Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4913 Heath Street 20743 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Rece - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementery/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Michael Bohin Theodosia Buchko 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Robert A. Mangum (Son) 9709 Post Oak Road Spotsylvania VA 22553 20b. Piace of Disposition (Name of cemetery, crematory or other piece) Feb. 2,2000 20c. Location - City or Town, Stets 20a. Method of Disposition 1 XBuriei 2 Cremation 3 Removal from State Maryland State Veterans Cem. Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funefal Service Li 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the claim. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediete Cause (Final disease or condition resulting in death) /Medical MYOCHROWN INFARCTIO **Examiner** Examiner g physician and as the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, certificate be Physician/Medical Due to (or es e consequence of): 980 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records, 200 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 O Yes 2 NA 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: Af investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical completely 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) To the To the To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D 0052247 MUHRY 27, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4333 Old Branch Avenue Marlow Heights, MD 20748 Collen D. Cullen M.D. 32 Registrar's Signature 31. Date filed (Month, Dey, Year) FEB 0 1 2000

DHMH 16 Rev 6/95

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 52 14

| | | | Certificate | of Death | Re | g. No. | 006.1 | |
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| | Decedent's Neme (First, Middle, Last) | | 77.5 | | 2. Date of Death Month | | 3. Tima | of Death |
| Physician Medical/ | (barles A Ma | rceron | | | January | 30, 200 | | PM |
| Examiner | An English Alama Manakanakanakan atau atau atau atau atau atau | er) | | 4b. City, Town, or L | | 4c. County of | | |
| | 216 Ella Welch Way | | | Lothian | | Anne A | Arundel | |
| Funeral Director | 5. Social Security Number 6. Sex. 7. 578–44–8196 | Age (In yrs. last bir 66 | thday) If Under 1 Months I | Year If Under 24 Hrs. Days Hours Min. | 8. Dete of Birth (Month, Day, Jan . 30, | 1934 V | 9. Birthplace (Stata Country) Vashington | n , D . C |
| ryland thew Lat | Usuel Residence of Decedent 10a. Stete 10b. County | 10c. City, Town | n or Location | | | | 10d. Inside | |
| A Paris | Maryland Anne Arundel | Lothi | ian | | | | 1 ∐ Ye | s 20 No |
| death with the Maryland ms 23a or 28e-f show cmatch notified at neral Director | | | 10f. Zip Co | | 10 | og. Citizen of W USA | | |
| flar death in the flam 23 siner must | 11. Marital Status 12. Was Decede | ent Ever in U,S. | 13. Wes Deceder | t of Hispanic Origin? (Sp Cuban, Mexican, Puerto | pecify Yes or No- | | - American Indian, | |
| 3 22 3 | 3 ☐ Widowed 4 ☐ Divorced H Yes, Give Year or Dete | □No 195/- | 1 Yes, specify | | o Hican, etc.) | Specify: | White, etc. | |
| 12 ho | 15. Decedent's Education | 16a. | Decedent's Usual C | occupation | kina | 16b. Kind of Bus | siness/Industry | |
| d 2 should be filed within 72 hours all this and Mental Hygiens 1. The marked other than "natural", or traumatic event, the Medical Examp To Be Completed by F | (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4-11) | or 5+) | | fone during most of work retired) rician | King | Constru | iction | |
| Barren O | | | | | na (First, Middle, N | faiden Sumeme |) | |
| uld be if Mental H rised of the even | Bertram M. Marceron | | | Ethel | Howard | | | |
| The state of | 19a. Informent's Neme/Relationship (Type, Print) | 19h | Mailing Address /5 | treet and Number or Ru | ral Route Number | City or Town 5 | State Zin Code) | |
| and 2 sho saith and n 27 is me er tracers | Shirley J. Marceron/Wife | | Same as | | | | | |
| semit. Pages 1 ar Jepartment of Hea reportant: if Item 2 my Injury or other IDGS. | 20e. Method of Disposition 1 🖫 Burlal 2 🗆 Cremetion 3 🗀 Removel from Ste | cemeter | Disposition (Name y, crematory or othe | r plece) | | | City or Town, State | |
| Part Part Part Part Part Part Part Part | 4 Donation GOther (Specify) | Cedar | Hill Cem | - | | Suitland | 1,Md. | |
| Departiment Important Impo | 21. Signeture of Funeral Service Licensee | | | P. Kalas Fu on Hill Rd. | | | 20745 | |
| | 234. Pent 1. Enter the disease, or complications that ceu | sed the death. Do r | | | | | Approximi | ate |
| death certificate be executed e attending physician and of for use as the burial-transit sician/Medical Examiner | Sequentially list conditions, if any, leading to immediate | tension Dua to (or as a c | consequence of): | | | | | |
| | Conor | estive Hea | re | | | | | |
| sed for sici | Part II. Other significant conditions contributing to deati | h but not resulting In | the underlying ceu | se given in Pert I. | 23b. Dfd to | bacco use con | tributs to the cause | s of death |
| | | sease | | | 1 🗆 Ye | 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknow | | |
| The law requires that the law reduires that the page 2 should be deteched by Physical Completed by Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Phy | | | | | 24a. Was ar perform | n autopsy ned? | 24b. Were autopsy available prior completion of of death? | orto |
| he te ha age age | | | | | 1□ Ya | s 2 No | 1 ☐ Yes 20 | □No |
| stan: Telen: Setor, p | 25. Was case referred to medical | 26. Place of | | | | | | |
| hysician: The his certificate of director, per To Be Co | | atient 2 ER/Ou | tpatient 3□ DOA | Other | ome NYReside | | r (Specity) | |
| | | | Time of njury M | | 28d. Describe ho | | | |
| bai or Attending Phy rs after death. rs after death. al Director: After this led in by the funeral d Certification: T | 3 Suicide 6 Could not be detarmined 28e. Place of building, | fnjury - At home, far etc. (Specify) | rm, street, factory, o | y, office 28f. Location (Street and Number or Rural Route City or Town, State) | | | r or Rural Route Nu | ımber, |
| he Hospita in 24 hours he Funeral pletely fille edical C | 29e. Certifier (Check only 2 Medical Examiner: On the basis and manner | s of examinetion and | , deeth occurred at a d/or investigation, in | he time, date and plece my opinion, daeth occu | , and due to the ca rred at the tima, da | use(s) and mar ate and place, a | nnar as stated. nd dua to the cause | ∍(s) |
| To the comple | 29b. Signeture end title of certifier | 1. m.n. | | icense number 28623 | | | (Month, Day, Year) 31, 2000 | |
| (10) | 30. Name and address of person who completed ceuse of Glenn R. Edgecombe, M.J. | | | Ave. Clint | on, Md. 2 | 0735 | | |
| State | | strer's Signature | | | | | | |

DHMH 16 Rav 6/95

FEB @ 1 2800 Some of money

| Please | Type or Print State of Mar | yland / D | epartme | ent of H | lealth a | | | 41 | ble. | 05215 |
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| | | | Certifica | ate of | Death | | | leg. No. | - 0 | |
| Decedent's Name (First, Middle, La James Rober | | | | | | | 2. Date of Dea Month | Day | Year | 3. Time of Death |
| | | | | | 4h Cihi Tow | | JANUARY cation of Death | 1 | | 07:30 A.N |
| 4a Facility Name (If not institution, given MALCOLM GROW MED) | | | | | CAMP S | | | PRINC | | ORGE'S |
| 5. Social Security Number 6. 5 | | In yrs. lest birt | | der 1 Yeer | If Under 24 | 4 Hrs. | 8. Dete of Birth | Veer | 9. Birth | plece (State or Foreig |
| 577-20-4919 | M 20F | 77 \ | rrs. Month | IS Days | Hours | MIII. | Month Dey | 1922 | Port | smouth, Va |
| Jsual Residence of Decedent | | | | | | | | | | |
| Maryland Prince G | | Oc. City, Town | stville | 2 | | | | | | 10d. Inside City Limits 12 Yes 2 □ No |
| Oe. Street and Number | 0 | | 10f. 2 | Zip Code | | - | 1 | 10g. Citizen of | What Cou | intry? |
| 6610 Lacona St. | | | | 207 | 47 | | | United | Sta | tes |
| 11. Meritel Stetua 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Wes Decedent Even Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: | er in U,S. | | | dispanic Origi an, Mexicen, Specify: | in? (Spe Puerto f | ecify Yes or No- Rican, etc.) | Bla | ce - Amer ck, White y: Blac | |
| 15. Decedent's E | | 16a | Decedent's Us | sual Occur | ation | | | 16b. Kind of B | usiness/li | ndustry |
| (Specify only highest gra | ade completed) | 100. | (Give kind of life. DO NOT | work done | during most o | of workir | ng | | | , |
| Elamantary/Secondary (0-12) | College (1-4or 5+) | | | | | | ervisor | Gove | rnmei | nt |
| 17. Father's Name (First, Middle, Last |) | | | | - | - | (First, Middle, | | | |
| James A. Mingo | | | | | Dor | | Villiams | | | |
| 19a. informant's Neme/Relationship (| Type, Print) | 19b. | Mailing Addre | ass (Street | end Number | or Rura | I Route Numbe | r, City or Town | Steta, Z | ip Code) |
| Marie Mingo/Wif | e | 66 | 10 Laco | ona S | t. For | estv | ville, N | Md. 20 | 747 | |
| 20a. Method of Disposition 1⊠ Burial 2 ☐ Cramation 3 ☐ | Ramoval from Stete | 20b. Place of cemeter | Disposition (A y, cremetory o | vame of or other pie | се) | 1 | Date | 20c. Location | - City or T | own, State |
| 4 Donation 5 Other (Special | | Linc | oln Cer | | | | /1/00 | Suitla | nd, | Md. |
| 21. Signeture of Funeral Service Licy | 1800 | | | | S. Po | | Funeral | Homes | | |
| Seith a. A | Zeros MIDS | 3 | 5538 | Mar1 | boro P | ike | /Forest | ville, | Md. | 20747 |
| 23a. Perf1. Enter the disease shock, or heert failure. In the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont | a. CHRONIC | OBSTRU | | PULMO | | | | | 1 | Interval Between Onset and Deeth |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | C | | onsequence o | | | | | | | |
| Part II. Other significant conditions of PROSTATE CANCER | ontributing to death but r | not resulting In | the undarlying | g ceusa gi | van in Pert I. | | 23b. Did t | | 3 Pr | to the causs of death obably 4 Unknow |
| | | | | | | | 24e. Was perfor | an autopsy med? | 8 | Vere autopsy findings valiable prior to completion of cause of death? |
| | | | | | | | 1 D Y | es 2 No | 1 | □Yas 2□No |
| 25. Was casa rafarred to medical | | | | | 26. Place | of Death | (Check only o | ne) | | |
| examiner? | Hospital: | 2□ ER/Out | tpatient 3 | DOA Oth | ner: 4 Nur: | sing Hor | me 5 Resid | lence 6 🗆 Oti | ner (Spec | cify) |
| 7. Manner of Death 1. Natural 5 Pending Investigatio | 28a. Date of Injury (Month, Day Y | ime of njury M | 28c. Injury et Work? | | | 28d. Describe how injury occurred | | | | |
| 2 Accident Investigatio 3 Suicide 6 Could not b determined | e Ogo Disco of Joins | - At home, farm, straet, factory, office | | | | | 281. Location (Street and Number or Rural Route Number, City or Town, Stata) | | | |
| (Check only 2 Medical Example 1997) | ysician: To the best of r | camination and | , death occurre | ed at the ti | me, date and | piace, a | and dua to tha ded at the time. | causa(s) and m | annar as | stated. to the cause(s) |
| one) | and menner stete | | | | | | | | | |
| 29b. Signeture end title of certifier Sharau | R OB | ils. | | 29c. Licens | | | | 29d. Date sign | | |
| 30. Name and addrass of person who | completed cours of deal | th (Item 22a) / | | כנו עויי | 2333 | | | JANUARY | 20, | 2000 |
| SHARON O'BRIEN, | | | | SAIR | FORCE | BAS | SE, CAM | P SPRIN | GS. | MD |

Registrar

State

FEB 0 I 2000

Physician /Medical Examiner

Funeral Director

pernit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiens.

Department of Health and Mental Hygiens.

Important: if them 27 is marked other than "netural", or itsens 23s or 23s-f show any injury or other traumatic event, the Medical Examiner must be notified at ances.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The lew requires that the death certificate be assocuted Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

5830 1 2000 James M. April 20

Please Type or Print In Black Indelible 1. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 05216 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Physician January 26,
4b, City, Town, or Location of Death 4c. Co Medical Ross McKeithan 2000 3:40 PM 4a Facility Nama (If not institution, give street and number) Examiner Forestville, MD Prince Georges

r | Hours | Min. | 8. Date of Birth | Month, Day Year) | Min. | March | 19,1948 | Laurinburg, NC 1325 Alberta Drive If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Months **X**□M 2□ F 51 Yrs. Director 238-76-2202 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Yas 2 No Maryland Prince Georges Forestville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Alberta Drive 20747 **United States** Funeral 14. Rece - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 20 No 11. Marital Status fled within 72 hours after 1 Never Married 2 Merried 8 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Banker Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other trearmetic event aloas. å Mitchell McKeithan Anna Brown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Irene McKeithan / Wife 1325 Alberta Dr., Forestville, MD 20747 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Date Hillside Cemetery 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 2/2/2000 Laurinburg, N. Carolina 21. Signature of Famoral Service Licensee 22. Name and Address of Fecility
Pope Funeral Homes 1700753 arry 1. 5538 Marlboro Pike, Forestville, MD commons 20747 23a. Part1. Enter 1.6 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hapf failure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical J MONTH HEPATIC FAILURF Examiner Due to (or as a consequence of) Examiner 2 weeks The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): SICKLE CELL DUEMA Physician/Medical Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Were autopsy findings Be Completed 24a. Was an autopsy performed? available prior to completion of cause of death? 1 ☐ Yes 1 Yas 2 No Physicien: 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? or Attending 1 Natural 5 Pending investigation a effer de... al Director: Afr 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Mospital within 24 hours or To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of condition DEMD 12508 MA 30. Name and address of person who completed gause of death (Item 23a) (Typer Print) WASHINGTON DC NW 20007

State Registrar

HORNE"

WK

FEB 0 1 2000

31. Date filed (Worth, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

of Vital

Division

25.0 1 2008 in the state of the state

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

| | 0 | 0 | 5 | 2 | - | 7 |
|---|---|---|---|---|---|---|
| _ | | | | | | |

| | 1. Decedent's Nan | ne (First, Middle, La. | st) | | | | | 2. Date of Dec | | | 3. Time of Death |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------|------------------------------------------------|-------------------------|--------------|---------------------------------------------|--------------------------------------------|------------------------------|-------------------------------|---------------|----------------------------------------------------|
| Physician | Cath | erine H | . Manta | zouran | is | | | Januar | y 27,2 | 0000 | 6:00pm |
| /Medical | 4a Facility Name | If not institution, aiv | e street end number) |) | | | 4b. City, Town, or | | | | |
| Examiner | The second second | Cross H | | | | | Silver | | , | tgome | erv |
| Funeral | 5. Social Security I | | | ge (In yrs. last l | oirthday) | If Under 1 Year | | | | - | _ |
| Director | 578-56- | | □M 2XF | 63 | Yrs. | Montha Days | Hours Min. | May 19 | , 1936 | Brook | Nace (State or Foreign otry) OKlyn, N.Y |
| D | Usual Residence | of Decedent | | | | | | 1 | 7.000 | | 7.07 |
| the sylen | 10a. State | 10b. County | | 10c. City, To | | | | | | 1 | Od. Inside City Limits |
| the Man 28a-f sh notified | Md | Montgom | ery | Rock | VIII | е | | | | | 1 ☐ Yes 2 🖺 No |
| 5 52 0 | 10e. Street and Nu 13107 B | urlwood | Drive | | | 10f. Zip Code 2085 | 3 | | 10g. Citizen of N USA | What Cour | try? |
| her death y r llems 23a siner.mutt | 11. Marital Status | | 12. Was Decedent Armed Forces? | Ever in U,S. | 13. Wa | s Decedent of | Hispanic Origin? (S ban, Mexican, Puert | pecify Yes or No- | 14. Rac | e - Americ | |
| O at an UT | 1 Never Man | ried 2 Married | 1 Yes 2X | | | Yes 20 No | | o ricali, etc.) | | ck, White, | |
| DO2 | 3 ☐ Widowed | 4 ☐ Divorced | Year or Dates: | | 1 | 1 105 21110 | эрвиу. | | Specin | /: ***** | |
| 1 21215-0 led within 72 ho lygiene. her than "natur it, the Medical. Completed | (Spe | 15. Decedent'a Ed | | 16 | a. Deceder | nt's Usual Occu | petion during most of wor ed) | rkina | 16b. Kind of B | usiness/Inc | Justry |
| 121 mg | Elementary/Sec | | Coilege (1-4or | 5+) | | | | | Dank | -6 | NI - *** |
| Co need Co | 12 | | | P | rocu | rement | Analys | | Dept. | | Navy |
| Maryland 21215-0020 d 2 should be fised within 72 hours at the and Markett hypinates, or traumstic event, the Medical Exam To Be Completed by 1 | | (First, Middle, Last) el Haran | | | | | | ne (First, Middle, Sigela | | ne) | |
| | | eme/Relationship (tine Mar | | | | | ot and Number or Ru 7 Burlw | | | | , Md 20853 |
| altimore, mit. Pages 1 at partment of Hea portent: If Nem. 3 7 Injury or other | | | Removal from State | | | ion (Name of tory or other pli Heaver | Cemete | ry 2/02 | 20c. Location - 2 / 0 0 S: | | r Spg, Md. |
| Baltii permit. Posparm importar any inju | | uperal Service Licen | | / | 22. PH | Name and Addr | ess of Facility | I FUNE | RAL SE | RVIC | E Spring Md |
| | 10 | wy W. | Kuleya | 7 | | | | | | ver | Spring, Md |
| THE REAL PROPERTY. | shock, or hea | art failure. List only | plications that caused one cause on each li | a the death. Do ine. | o not enter | the mode of dy | ing, such es cardiad | or respiretory ar | rest, | 1 | Approximate Interval Between Onset and Death |
| Physician // // // // // // // // // // // // // | Immediate Cause | /Einal | ٨ | r C |) | ٨ | ۸ ۰ ۰ | | | 1 | Oriset and Death |
| Examiner | Immediate Cause diaease or condition resulting in death) | on | · Acu | le K | ena | 1 - | allur | 2 | | | week |
| The same of | | | | Due to (or as | a conseque | ence of): | | | | | |
| nin nsit | | | b | Se | P&U | | | | | i | Iweek |
| 60, be executed idean and burial-transit | Sequentially list co if any, leading to in cause. Enter Under | onditions, nmediate | | Due to (or as | conseque | ence of): | | | | i | |
| | Cause (Disease or that initiated event | injury | c | 0.11.6 | | | | | | 1 | |
| Sox 6876(th certificate be tending physicia w use as the bu an/Medical | resulting in death) | | | Due to (or as a | i conseque | nce or): | | | | | |
| Box ath certification use or use | | | d | | | | | | | | |
| | Part II Other elani | floort conditions or | entellection to doubt b | us not constitue | In the cond | a-b-in-n-n-n-n | ives in Bod I | 22h Did e | ohaaaa uua aa | manifer de de | the cause of death? |
| P.O. B nat the death d by the aute setteched for Physicia | | | ontributing to death b | | | | | | on 2□ No | 3 Proi | the cause of death? |
| T 4 50 T | | etaste | utic 1 | breas | + | au c | er | | 2010 | 3 | ALGO VINCIONII |
| Vital Records, P.O. Idean: The law requires that the decentificate has been signed by the a rector, page 2 should be detached it. | | | | | | | | 24a. Was | an autopsy | 24b. W | ere autopsy findings ailable prior to |
| al Record The law requir The law requir The law requir The law requir The law requir The law required Completed | | | | | | | | репо | med? | CO | mpletion of cause death? |
| Il Rec The law ate has b page 2 s | | | | | | | | 1000 | 'es 2□No | | Yes 2 No |
| Vital Indiana The Contificate rector, pag | 25. Was case refe | red to medical | | | | | 00 Pi (P | / | | | 1165 200110 |
| Of Vita Physician: this certific rai director, | examiner? | | Hospitei: | ent 2 ER/0 | Dutantiant | 3D DOA | thos | ath (Check only o | | ar /Passit | L1 |
| Physical distriction of T. To | 27. Manner of Deal | | 28a. Date of Inju | | . Time of | 28c. Inju | | 28d. Describe h | | | 7) |
| ding in Affer of fune | 1 Netural 2 Accident | 5 Pending investigation | | y Year) | Injury | | ork?]Yes 2∐No | | | | |
| Division after death. Director: After in by the fune ertification | 3 ☐ Suicide | 6 Could not be determined | | ury - At home, | ferm, stree | t, factory, office | • | 28f. Location (5 | treet and Numb | oer or Rura | Il Route Number, |
| Division Amanda after day of in by | 4 Homicide | dotominod | building, ef | c. (Specify) | | | | City or Ton | n, State) | | |
| and Allie | 29a, Certifier | Certifying Phy | sician: To the best | of my knowledg | ge, death o | ccurred at the t | ime, date and place | , and due to the (| cause(s) and ma | anner as s | tated. |
| Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification: | (Check only one) | 2□ Medical Exam | iner: On the basis of and manner str | f examinetion a | ind/or inves | stigation, in my | opinion, death occu | irred at the time, | date and place, | and due to | the cause(s) |
| Neithin Somp | 29b. Signature and | I title of certifier | | | | | ise number | | 29d. Date aigne | | |
| | A | MOIA d | 0112 80 | oto n | un | DZ | 862 | | Janua | au. | 28 2000 |
| (6) | 30 Name and add | race of pareon who | completed cause of d | leath /Item 22a | \ (Tune D- | int) | 0 - | | 0 | 7 | , 5000 |
| 0 | Du Mi | PAA CALA : CO | 2/16 211 | 101 Re | MP CL | (C) - B1 | VD Su | Ite 34: | s Kock | vill | 28, 2000 a M.D. 850 |
| | 21 Date filed #4co | th Con Your | 20 Do-In- | aria Cianatura | 2001 | | | | | | 20000 |

State Registrar

JAN 3 1 2000

32. Registrar's Signature

DHMH 16 Ray 6/95

1AN 2: 2000 Same S. Marson

| State o | f Maryland / | Department | of Health | and l | Mental | Hygiene |
|---------|--------------|------------|-----------|-------|--------|---------|

05218 Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death 3, 2000 **Physician** MckimmiE JOSEPH 2:20 AM STEPHEN February /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Prince George's Ft. Washington H Under 1 Year H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 10, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 10 MM 2□ F 578-03-3872 79 Yrs. 1920 Washington, D.C. Director Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 26s-f show the Medical Examiner must be notified at Maryland Prince George's Accokeek 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15913 Dusty Lane 20607 U.S.A. death 12. Wes Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 □ No 1944 – If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status filed within 72 hours after of Hygiene. Phatural, or her 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry D. C. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Phyllens.
Importants if item 27 is marked other that only on high nice or other treumatic event, the items. Policeman Metropolitan Police 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John Matthew McKimmie Mabel Irene Sanford 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Marion A. McKimmie/Wife 15913 Dusty Lane, Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stele
4 Donetion 5 Other (Specify) , St. Mary's Cemetery 02-05-2000 Piscataway, Maryland 21. Signature of Funeral Service Ligaria 22. Name and Address of Facility The Huntt Funeral Home, Inc. JOHN P. KNISLEY P.O. Box 156, Waldorf, Maryland 20604 M01164 mew 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) INSUFFICIENCY 1-2HRS Examiner Physician/Medical Examiner C.O.P.D. OF 3WKs EXACERBATION physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. LUNG DISEASE YYS. OBSTRUCTIVE CHRONIC Due to (or es a consequence of) 80 080 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? Toa 2 No 3 Probably 4 Unknown HYPERTENSION, SEVERE VASCULAR DISFASE, Records, Completed by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? SP MULTIPLE VASCULAR GRAFTS, REQUIRING COUMADIN. COLON CA SIP RESECTION, WICER DISEASE. 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitel: 15 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation or Attending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edical (Check only one) To the

State Registrar

31. Date filed (Month, Day, Year) FEB 07 2000

Sinivasan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature end title of certifier

32. Registrar's Signature

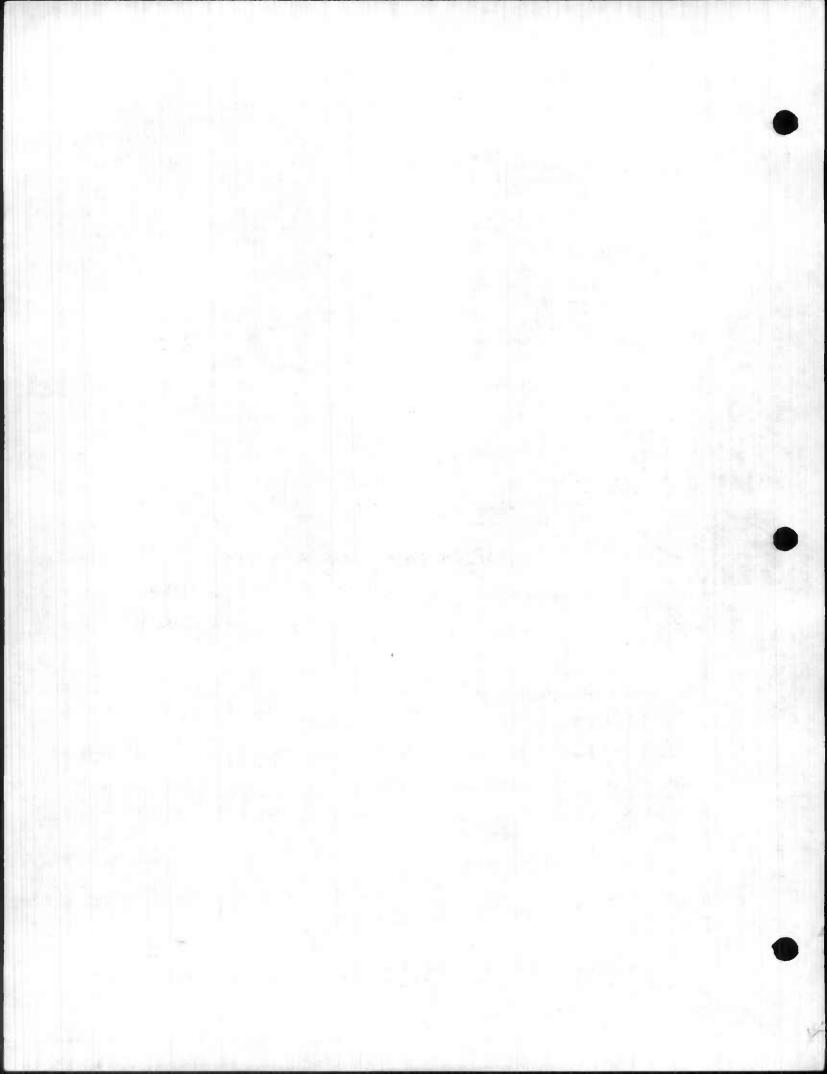
G. SRINIVASAN, 8926, WOODYARD RD#601, CLINTON MD 20735.

29c. License number

D 46345

29d. Dete signed (Month, Day, Year)

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) February John Arthur McKay, Sr. 3,2000 12:05AM 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 3218 Westdale Court Waldorf Charles 6. Sax 1XXX 2□ F If Undar 1 Yaar | If Undar 24 Hrs. 6. Data of Birth (Month, Day, Year)
March 28, 1945 Maryland 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 5. Social Security Number Days Min 54 Yes 114-34-5543 Usual Residence of Decedant 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County 1 Yas 2 No Maryland Charles Waldorf 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 20601 USA 3218 West Dale Court 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 XX as 2 □ No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married White 1 ☐ Yas 2 🖾 No Specify: 1962 3 Widowed 4X Divorced 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Electronics Machinist 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Otha Sylvester McKay Olive Belle Reste 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 2720 Vista Ct., Waldorf, MD 20603 John A. McKay, Jr. - Son 20b. Placa of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burlal 2 Cramation 3 Ramoval from Stata Trinity Memorial Gardens 2-5-00 4 ☐ Donation 5 ☐ Othar (Specify) Waldorf, MD 21. Signethere of Funeral Belvice Licenses 22. Nama and Address of Facility Trinity Memorial Gardens John P. Knisley P 0 Box 156, Waldorf, MD 20604-0156 M01164 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Lung Cancer with metatasis to bone, liver Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated events Dua to (or as a consequence of): Dua to (or as a consequence of) rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying couse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Desidance 6 Othar (Specify) Hospital: 1 ☐ Yas 2XX10 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

r than "natural", or items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other treumatic event, the Modical Examiner mustle once.

Baltimore, Maryland 21215-0020

with the Maryland r 28a-f show

> physician and the burial-transit 88 US8 Por been signed by the should be detached

the death certificate be executed Tha law requires that cartificate has t page or Attending Physician: After this death. the Hospital

Division of Vital Records, P.O. Box 68760,

2 Certification:

þ Completed

edicai

27. Mannar of Death

X Natural

3 ☐ Suicida 4 | Homicida

(Check only

29a. Cartifiai

Physician/Medical Examiner Be

within 24 hours after death To the Funeral Director: / completely filled in by the within 2

> State Registrar

29b. Signatura and titla of certifier

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. Licensa number

1XX ertifying Physician: To tha best of my knowledgs, dasth occurred at tha time, data and place, and dua to tha causa(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

D28352

29d. Data signed (Month, Day, Year) February 3, 2000

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

28b. Tima of Injury

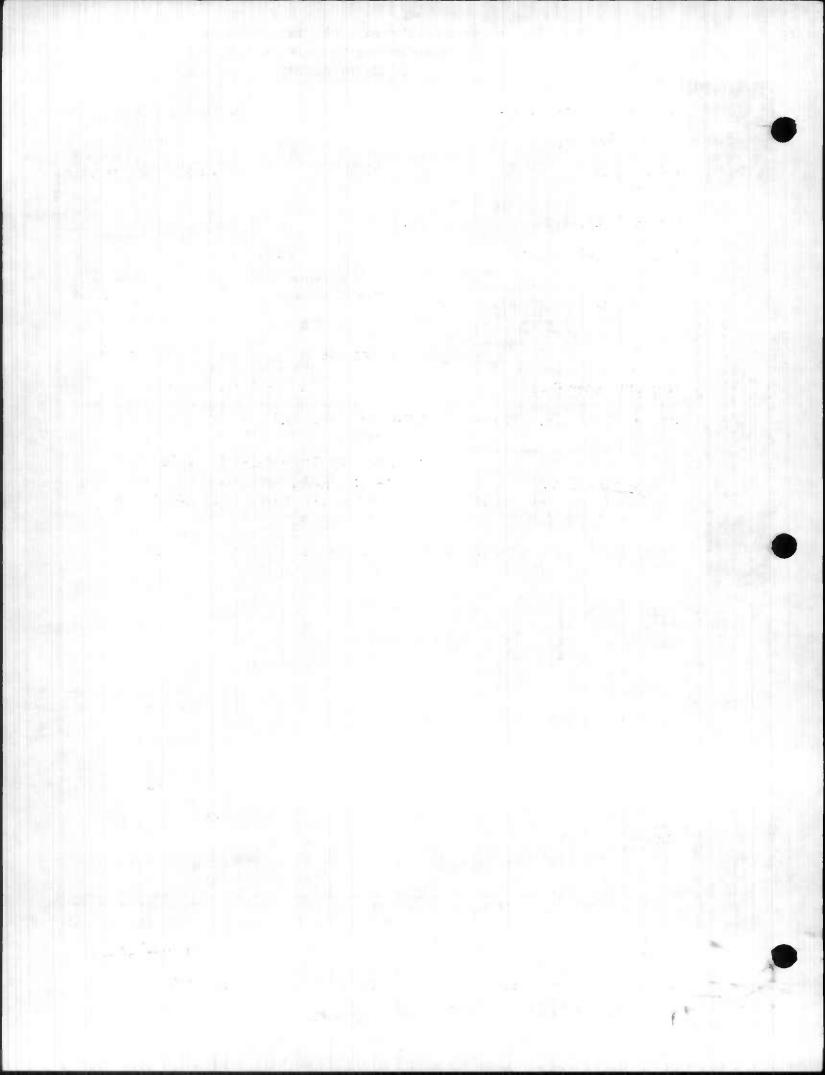
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

2000

5 Pending invastigation

6 Could not be datarmined

32. Registrar's Signatura



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NEWBY **Physician** Month February MARY 2000 9:00 P.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Lusby Calvert 50 Appeal Lane #317 If Under 1 Yeer | ff Under 24 Hrs.

Months Deys Houra Min. 8. Dete of Birth (Month, Day, Year) Apr. 18, 1 5. Sociel Security Number 7. Age (In yrs last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1□ M 2 F 219-28-6309 Yrs 1929 Maryland Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or frams 23a or 28a-f ahow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Calvert Lusby Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20657 50 Appeal Lane #317 permit. Peges 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frams 23a any injury or other traumatic event. USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 21 Merried Baltimore, Maryland 21215-0020 Black. 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Someone Else's Home Domestic 17. Father's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Melden Sumeme) Christine Phillips | Vincent Johnson 19e. Informent'a Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 38430 Barbara Court Mechanicsville, MD 20659 Lynette Savoy/Niece 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Removal from Stete 2/8/00 Dunkirk, MD 4 □ Donation 5 □ Other (Specify) Southern Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 Lewel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical POSSIBLE MI immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be associated Zahours after death.

Zahours after death.

Fueral Director: After this certificate has been signed by the attending physician and element of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as e consequence of) Pert II. Other signiticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SICK SINUS SYMPRUME SIO PACEMAKER PLAIEMENT Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ HYPOTHURUIDISM, NARIOLEPSY, HTN, COPD 24e. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed 518 (VA 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? Be 28. Piace of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 NONO 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai To the 29b. Signeture and title of cardinar 29c. License number 29d. Date signed (Month, Day, Year) 2/3/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1510 HGTRVEMAN RO LUSBY MD 20657 MATHEN MO

State Registrar FEB 0 7 2000

5 32. Registrar's Signature Sparks

The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa

Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Gladys Marie Newby Death 4c. County of Death /Medicai 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death" **Examiner** Union Hospital Elkton If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 254 Yrs. Director 80 Nov. 14, 1919 Kentucky 311-12-6517 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits *how traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo 288-f Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 18 Tree Lane 21921 Items 23a U.S.A. daath Funeral 11. Marital Stetus 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. permit. Pagas 1 and 2 should be filled within 72 hours aftar a Department of Haalth and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examina-2010s. 1 ☐ Yes 2X No if Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 12 Domestic Engineer In home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William C. McClure Katherine Effie Perkins 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Earl L. Newby (Son) 18 Tree Lane, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete 4 ☐ Donation 5 ☐ Øther (Specify) Harford Memorial Gardens2/2/00 Aberdeen, Maryland 21. Signature of Furniral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. art1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one cause or each line. Approximete Interval Between Onset and Death **Physician** /Medical fmmediate Cause (Final neumonia disease or condition resulting in death) **Examiner** Due to (or es e consequence of): of Alzheimers Examiner years bomentia physician and s the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence of): d for usa as t Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ sata has been sig paga 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death
Director: A 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D complataly filled 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/28/2000 Lechders Mi) 30 Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

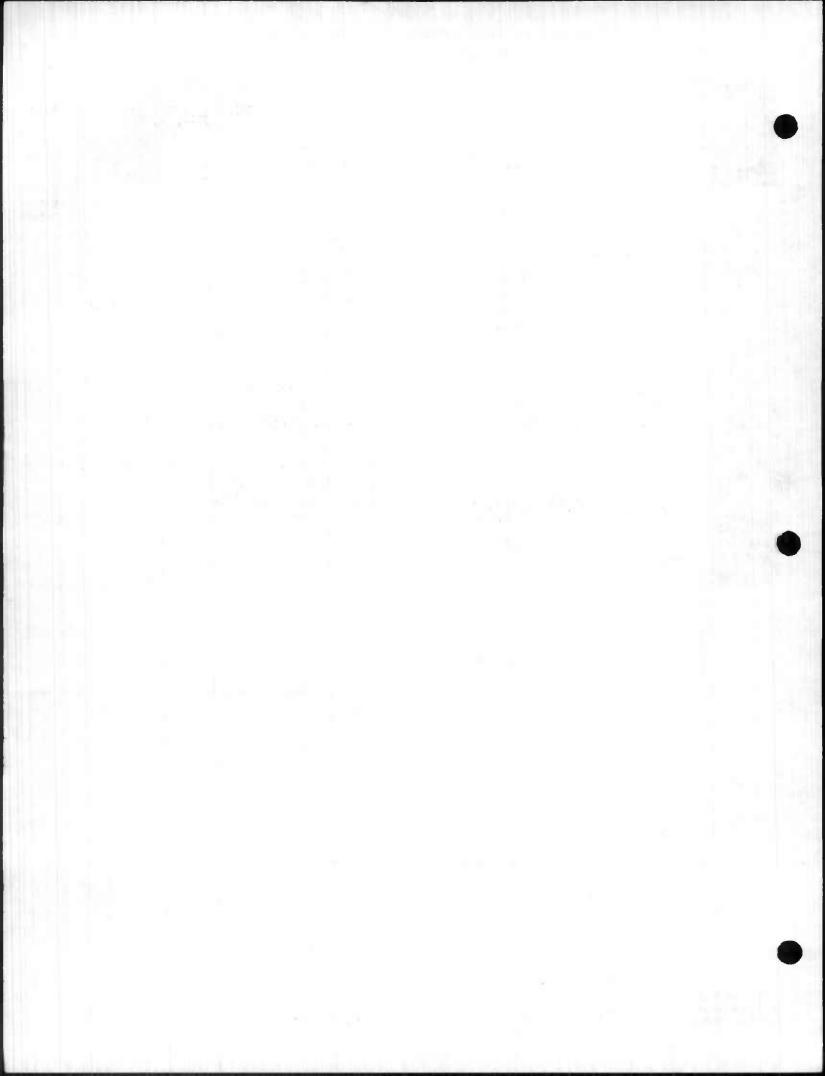
S. S. SACHDEU MD. 18 North Strate 3B, Elkan MD 21921.

State Registrar 31. Date filed (Month, Day, Yeer) 32. Registrar's

FFR T

32. Registrar's Signature

p. sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 05222

| | | | | Certi | ificate | of. | Death | | R | eg. No. | | |
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| Dhysisian | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of Dear Month | th Day | Year | 3. Time of Death |
| Physician /Medical | RICHARD ROM | | | | | _ | | | JANUARY | | | 12:26PM |
| Examiner | 4a Facility Name (If not institution, MALCOLM GROW | | | | | | 4c. County of Death CAMP SPRINGS PRINCE GEORGE S | | | | | |
| Funeral Director | 242 38 4241 | 6. Sax 1 □ kgM 2 □ F | 7. Age (In yrs. last b | | Months D | aar | If Undar Hours | 24 Hrs. Min. | 8. Data of Birth (Month, Day January | 15,193 | 9. Birthp Coun 1 Nort | laca (State or Foreig try) h Carolin |
| Maryland and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and show office and s | Usual Residence of Decedent 10a. Stata 10b. County Maryland Prince | e George' | s Suit | | ition | | | | | | 1 | 0d. Inside City Limit: |
| ter death with the Maryla there 23e or 23e-f show the mast be notified at Funeral Director | 10e. Street and Number 3701 Dianna Road | | | | 10f. Zip Co | | 746 | | 1 | 0g. Citizen of V | What Coun | try? |
| by by | 11. Marital Status 1 Nevar Married 2 Marrie 32 Widowed 4 Divorced | Armed F | 2 No ive 1952 - | 10 | as Deceden res, specify | | | | ecify Yes or No- Rican, etc.) | Blac | e - Americ ck, White, v: Bla | etc. |
| ed within 72 hours yglene. Ar than "natural", A, the Wides E. | 15. Decedent' (Specify only highest Etementary/Secondary (0-12) | grade completed) |) 16: (1-4or 5+) | a. Deceder (Give kir life. DC | nt's Usual Cond of work of NOT use i | lone etire | durin g mos d) | | ing | 16b. Kind of Bu | usiness/Inc | lustry |
| Se Se S | 17. Fathar's Name (First, Middle, L Rome Nixon | | | | | | | | | | | |
| nd 2 salth ar 27 is r frau | 19a. Informant'a Name/Relationsh Virginia Burney | | | | | | | | a <i>l Rou</i> te <i>Number</i> SAlisbur | | | |
| SOT | 20a. Method of Disposition Surial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetey 2-8-00 Arlington, 22. Nama and Addrass of Facility | | | | | | | | | | | |
| permit. Pages Department of Important: If I any Injury or price. | 21. Signature of Funeral Service L | Busa | ce-Tonie | 2 | | | | MAR | SHALL'S Suitlar | | | |
| and certificate be executed attacking physician and storage as the burist-center clanyMedical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events, resulting in death) Last | a | CARDIOPU Due to (or as a HYPOTENS Due to (or as a | I ON s conseque | ence of): | RE | ST | | | | | |
| of by the detached | | | | | | | | | | | | the cause of death |
| The law requires it sate has been signe page 2 should be C Completed by | PARKINSON'S I | DISEASE | | | | | | | 24a. Was a perfor | | 89 | ers autopsy findings allable prior to mpletion of cause death? |
| erificate has sctor, page 2 Be Comp | 25. Was case referred to medical | | | | | | 26 Pino | e of Deat | 1□ Y | 27 - 22 - 22 - 22 | 10 |]Yes 2□ No |
| After this cer funeral directions: To E | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could or | 25s. Date (Mor | nth, Day Year) | Time of Injury | М | | ner 4□N | ursing Ho | ome 5 🗆 Resid 28d. Describe h | ence 6 GOth ow injury occur | red | y) Il Route Number. |
| Hospital or Attend 24 hours after death Funeral Director: stely filled in by the dical Certifical | 4 Homicide determine 29a. Certifier 1 XCertifying | Physician: To Ibi | e of Injury - Al home. ling, etc. (Specify) artigst of my knowled; | ge, death o | ocurred at t | he tir | | | City or Tow | n, State) ause(s) and mi | anner as s | tated. |
| To the Hospital within 24 hours To the Funeral completely filled Medical Co | (Check only 2 Medical E | | egis of examination a mer stated. | ind/or inve | 1 | icene | se number | | | tate and place, | | |
| Va | 30. Name and address of person w George Leon, MD | Contract to the second second | se of death (Hem 23a Street St | | | | | | | -/ | / | |
| State Registrar | 31. Date Illear (Month, Day, Year) 32. Régistrer's Signature | | | | | | | | | | | |

DHMH 16 Rev 6/95

January 1997 2 0 833

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 05223 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Yea Sarah Louise Owens 1:20 AM January 23 2000 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ginger Cove Health Care Center Annapolis Anne Arunde1 If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Hours Davs 10 M 20 F Months Yrs June 9, 216-44-4545 93 1906 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5203 River Crescent Dr. 21401 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 Yes 27 No 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Year or Detes White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Selective Service Civil Service 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Zachariah Catterton Margaret Stamp 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred M. McNew/ Niece 1523 Meyer Station Rd. Odenton, Md. 21113 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \$\infty\$ Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) 01-25-00 Lothian, Maryland St. James Cemetery 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 Part Emer the didease, or complications shock, or heart feilure. List only one ceus ons that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, austral each line. Approximete Interval Between Onset end Death Immediate Cause (Finel diseese or condition resulting in death) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? No 25. Wes case referred to medical exeminer? 28. Placa of Deeth (Check only one) exeminer?
1 Yes 2 No
27. Manner of Death Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed Box 68760 Records, P.O. Division of Vital

Examiner physician and the burial-transit Physician/Medical USB the signed by p Completed Deed 188 certificate Be To this Ne Hospital or Attending Ph n 24 hours after death. Ne Funeral Director: After th Certification: the Hospital edicai

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

"neturel".

illed within 7 Hygiene.

permit. Pages 1 and 2 should be filled Department of Health and Mental Hygid Important: If teen 27 is marked other

Physician /Medical

Examine

Directo

Funeral

þ

Completed

Be

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

29e. Certifier (Check only one)

4 | Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner steted.

29b. Signeture a

JAN 2 7 2000

29d. Date signed (Month, Day, Year)

Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter R. Graze, M.D. 31. Date filed (Month, Day, Year)

32. Registrer's Signeture

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

900 Bestgate Rd. Suite 300

State Registra

within 2

JAN 27 2000 personer fil. spendy

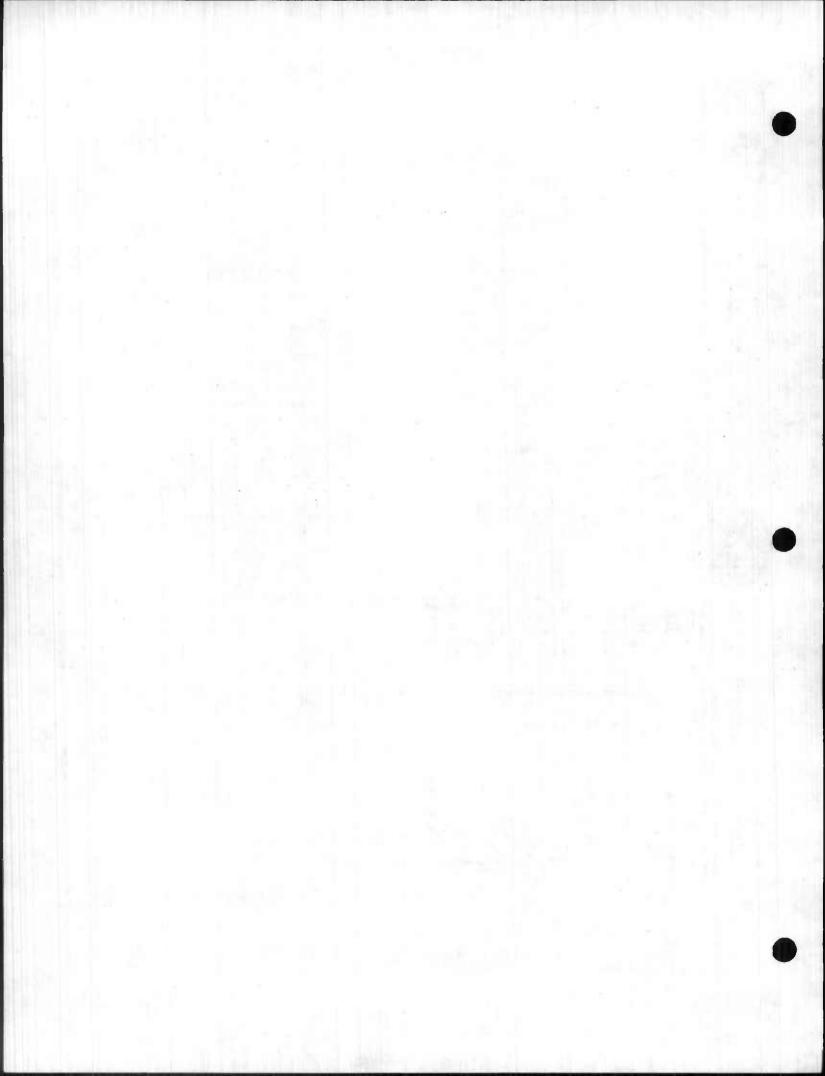
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

00 05224

| | | 1. Decedent's Ne | me (First, Middle, Las | () | | | | | | 2. Date of D | eath | | 3. Time of Death |
|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------|---------------------------------|---------------------------------------------------------------|---------------------------------------|-----------------|-------------|-------------------|------------------------|--------------------|----------------------------------------------|-------------|--------------------------------------------|
| | ysician | Goldie | Patricia (| Oldham | | | | | | Januar Januar | y 29, 20 | Year 000 | 3:45 PM |
| | Medical | | (If not institution, give | |) | | | | 4b. City. Town. o | r Location of Dea | | - | 10.0 |
| Ex | aminer | | owell Aver | | | | | | Hagerst | | | | n Counti |
| | _ | 5. Social Security | | | ge (In yrs. las | e histoday) | If Under | 1 Year | | | | | on County place (State or Foreign |
| Fund Direct | | 218-34- | | DM 2⊠F | _ | 1 Yrs. | Months | Days | Hours Mi | | ay. Year) | Cou | vland |
| - | | Usual Rasidence | | | | | | | | Dan 30 | 7 1550 | PRAL | yland |
| 0 M | 11 | 10a. Stete | 10b. County | | 10c. City, | Town or Loc | cation | | | | | 1 | 10d. Inside City Limits |
| with the Maryland is or 28a-f show | for fed | MD | Washingto | on Co. | Hag | erstov | vn | | | | | | 1 Yes 2 No |
| 2 P | be notified Director | 10e. Street and N | lumber | | | | 10f. Zip | Code | | | 10g. Citizen of 1 | What Cou | ntry? |
| 19 w 182 | 10 | 446 McI | Dowell Ave | nue | | | 2 | 2174 | 0 | | | U.S. | .A. |
| er desti | Funeral | 11. Merital Stetus | | 12. Wes Decedent | | 13. V | Ves Deced | lent of h | lispanic Origin? | Specify Yes or N | | | can Indian, |
| | B 5 | 1 Never Ma | rried 2 Merried | Armed Forces? | | | | | an, Mexican, Pue | orto Hican, etc.) | 11.00 | ck, White, | |
| 020 | by by | 3 D Widowed | 4 Divorced | If Yes, Give Year or Dates: | | 1 | ☐ Yes : | 2 LOS NO | Specify: | | Specif | v: Wh | hite |
| Maryland 21215-0020 42 should be filed within 72 hours at th and Mental Phyligene. 7 is marked other than "natural", or | c, the Medical | /90 | 15. Decedant's Ed | ucation | | 16a. Deced | ent's Usua | al Occup | pation | ndrina | 16b. Kind of B | usiness/In | dustry |
| 121 within | 퉦 | Elementary/Se | | College (1-4or | 5+) | | | | during most of w d) | O'Ally | O II | | |
| N NOW | # 6 | 9 | 9 | 0 | | Hom | emake | er | | | Own H | ome | |
| ind 2 | Be | 17. Father's Nam | e (First, Middle, Last) | | | | | | 18. Mother's N | ame (First, Middle | e, Maiden Suman | ne) | |
| hould by the marked | To | Floyd N | Mays | | | | | | Goldie | Patric | la Presg | raves | 3 |
| Aar 2 sho and is me | 5 | | Name/Relationship (7 | | | | _ | | | | ber, City or Town, | | |
| 0.71.04 | E b | Walter | E. Oldham, | /Husband | | 446 M | cDowe | ell | Avenue, | Hagersto | own, Mar | yland | 1 21740 |
| or Health | 6 | 20a. Method of D | | | con | ce of Dispos | sition (Nan | ne of ther pla | ce) | Date | 20c. Location | City or To | own, State |
| Pages hart of int. If its | č. | 255 | 2 ☐ Cremetion 3 ☐ I | | Ceda | ar Lav | m Me | mori | ial Park | Feb. 3 | Hagerst | own, | Maryland |
| = ### | injury St | 21. Signaturer-el, | Funerel Service Licens | S 0 8 | | 22. | Neme an | d Addre | ess of Facility | | | | |
| 00 89 8 | - SE | V. 1 | | 1017: | | Do | ougla | s A. | Fiery | Funeral | Home | Maxx | 1and 21742 |
| | | 23a. Part1. Ente | the disease, or comp | dications that cause | the death. | Do not ente | r the mod | e of dyir | ng, such as card | ac or respiratory | erstown, | Mary | land 21742 Approximate |
| Physic | ion | shock, of he | and dailure. List only o | one ceuse on each li | ine. | | | | | | | i | Intervel Between Onset and Death |
| /Medi | | Immediete Cause | | 44 | | 10 | | | | | | i | C . |
| Exami | ner | diseese or condit resulting in deeth | tion i) | a/V | lye los | | | | | | | | 5 years |
| | — • | | | | Due to (or a | is e conseq | uence of): | | | | | 1 | |
| Det . | Examiner | | | b | Due to fee | | | | | | | t | |
| By D | EX8 | Sequentially list of any, leeding to cause. Enter Un- | immediate | | Due to (or a | is a consequ | uence orj. | | | | | t | |
| 760 s be | - ES | Cause (Disease of the tinitiated ever | or injury | C | Due to (or e | | ionon offi | | | | | | |
| ox 68760, certificate be executed iding physiclan and | 2 3 | resulting in death |) Last | | Due to (or e | s e consequ | serioa org. | | | | | | |
| 0 - 5 | r use as the bush | | | d | | | | | | | | | |
| m 8 8 | icia Cla | Port II Other alor | nificant conditions co | atributing to death h | nut not resulti | ing in the un | rderhving c | ausa ai | ven in Pert I | 23h Die | I tohacco usa co | ntribute t | to the cause of death? |
| P.O. at the d by the | Physici Physici | r arrii. Other eigr | micant conditions co | throughly to death c | or nor result | ing in the time | loony my ca | ause yn | veri in r ott r. | | - | | obably 4 Unknown |
| That that | be det | | | | | | | | | _ ' | , 100 2 110 | • | , , , , , , , , , , , , , , , , , , , , |
| of Vital Records, Physician: The law requires the this certificate has been signed. | | | | | | | | | | 24a. Wa | s an autopsy | 24b. W | /ere autopsy findings vailable prior to |
| COL v requ | Should | | | | | | | | | per | formed? | CI | ompletion of cause I death? |
| Pe law | Completed | | | | | | | | | | | | |
| Vital I | 8 0 | 27 111 / | | | | | | | 7.2 | | Yes 2 No | 1 | ☐ Yes 2☐ No |
| of Vita Physician: this certific | director. | 25. Was case ref exeminer? | | Hospitet: | | | - | Ott | hor | eath (Check only | | | |
| Of this | | 1 ☐ Yes 2 ☐ 27. Menner of De | PNO | 1 LI Inpatie | ent 2 E | 8b. Time of | | <i>/</i> ^ | 4 LI NUISING | 1 | how injury occur | | <i>(y)</i> |
| Sing I | led in by the funer. Certification: | 1 Natural | 5 Pending | 28a. Dete of Inju (Month, Da | y Year) | Injury | M | 8c. Inju | rk? Yes 2 □ No | 20d. Describe | riow injury occur | 1100 | |
| Vision Attending or death. | 1 P | 2 ☐ Accident 3 ☐ Suicide | investigetion 6 Could not be | 00- Pl(1- | ives Ashan | | | | 1165 2 1140 | 20f Location | (Street and Num | har or Du | ral Route Number, |
| Division for Attending after death. | 1 T | 4 Homtolda | datermined | 28a. Place of In building, at | jury - At hom lc. <i>(Specify)</i> | a, iarm, stre | et, ractory | /, OTTICE | | City or To | own, State) | Der OF FIGE | ar riode rumber, |
| pital urs sur | 2 | 200 Cartifica | 450 position Division Division | -lalan Tarka basa | | | | -0.00 | 4-4 4 -1- | d alice do alice | | | -4-4-4 |
| Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After | completely filled in by the funeral Medical Certification: | 29e. Certifier (Check only one) | | ralcian: To the best iner: On the basis o and manner st | d examinetio | | | | | | | | |
| thin the | 1 N | 29b. Signatura ar | nd titla of certifier | and mannar st | 0.00 | | 290 | . Licens | se number | | 29d. Date signe | ed (Month. | Day, Year) |
| F 3 F 1 | 2 | | | on, | , | | | | | | - II- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- | | |
| | | | whal 1. | - /hels | work | , Mo | | () | 7166 |) | | 1.0 | |
| | | 30. Name and ad | drass of person who c | ompleted causa of c | death (Item 2 | 3a) (Type, I | Print) | | | 1 / 11 | | | |
| | | Michae 31 Dolo Had At | J. MCCO | mack | 1/110 | /re | dical | . (| unpos | 14. IT. | eserutou | ~~ | MO 21747 |
| Po | State gistrar | J1. Dete med (MC | FEB 01 20 | 100 SZ. Hegisti | ol s Signatu | B. | de | Day | 6 | | | | |
| 116 | giotia: | | | | | | // | - | _ | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** PHELPS Lewis Riley 2000 February 8:41 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthdey) 82 If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Social Securify Number Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Monfhs Days Hours Yrs. 215 38 9963 **Director** Aug. 19, 1917 TX Usuel Residence of Decedent with the Maryland 10a, Sfata 10h Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at MD Calvert Huntingtown 1 Yas 2 No Directo 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "naturel", or flems 23a yillying or other traumatic event, the Mod cal Examiner mans. 1280 Solomons Island Rd. 20639 USA Funeral 14. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, atc. 1 ☐ Yas 2 ☐ No
If Yes, Give
Yeer or Dates: 1938—58 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) career sailor, US Navy US Government 18. Mother's Name (First, Middle, Maiden Surnema) 17. Fathar's Name (First, Middle, Last) Reuben Lewis Phelps Dorothy Margaretta Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Helen L. Phelps (wife) same as 10 above 20b. Place of Disposition (Neme of cematery, crametory or other place) 20a. Mathod of Disposition Dafe 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Calvary Cem. (Hunt. UMC) 2-7-00 Huntingtown, MD 21. Signature of Funeral Service Liganer 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximate tritervat Between Onsef and Death **Physician** /Medical Immediete Cause (Final End Stage Cor Pulmonale
Due to (or es e consequence of): disease or condition resulting in death) Examiner Due to (or es e consequence of):

Cosclepte Cadiovascula Disease Examiner attending physician and for use as the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 3 No 3 Probably 4 ☐ Unknown Lymphony PV 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? F. brillation page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate funeral director. 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1. Nopafianf 2 ER/Outpatient 3 DOA 2 1 Yes 2 No After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 12 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - Af home, farm, street, factory, office buttding, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

or Attending Physicien: 24 hours after death. filled in by Hospital completely To the P within 2

1 VA

Registrar

Jonathan Lowenthal, MD 31. Date filed (Month, Dey, Year) FEB 0 7 2000

29a. Certifier

(Check only one)

29b. Signeture end title of certifier

edical

Prince Frederick, MD 32. Regisfrar's Signeture

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

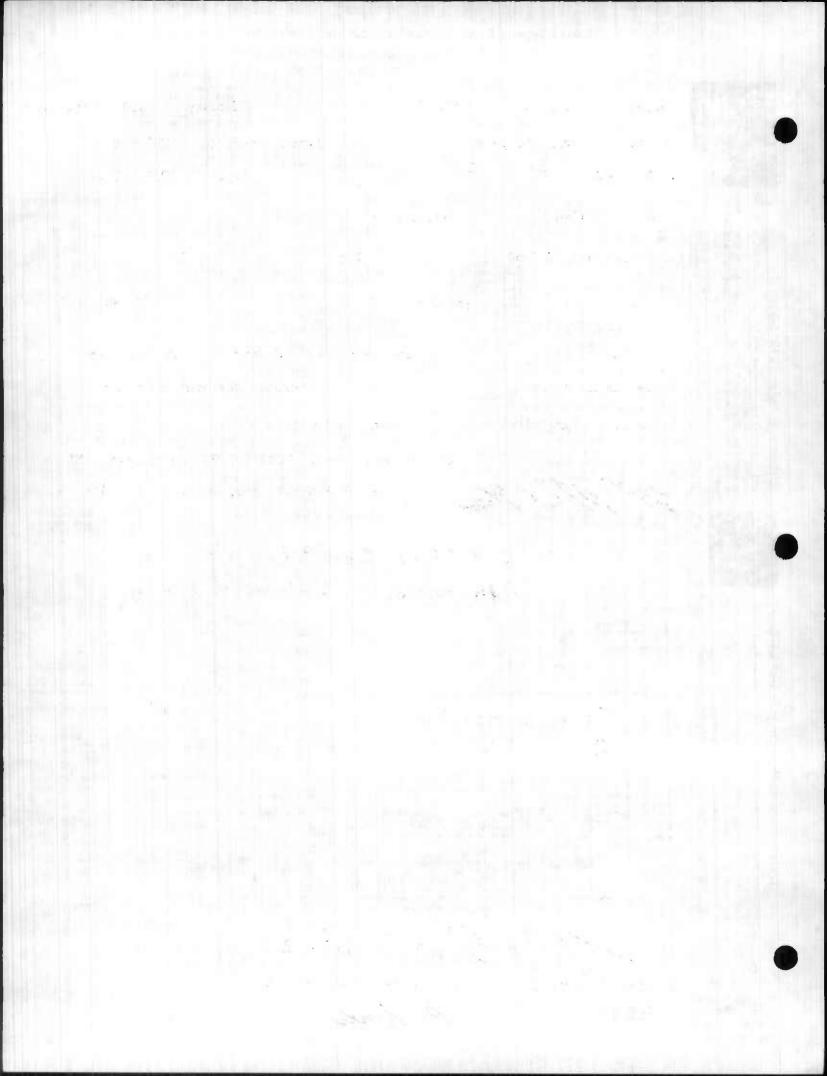
125 certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

03312

29d. Date signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day PLUMMER AMES JANVARY 28 2000 OYO or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death THE JOHN 5. Social Security Number JUHNS 40PKINS 8. Date of Birth (Month, Day, Year) If Under 1 741 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Hours 1₩ 2□ F Days Min. 1945 Maryland Jan. 220-40-7853 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 578 Pearl Street 21911 U.S.A. 12. Was Decedent Evar in U.S. Armed Forces? 1 to Yes 2 □ No If Yes, Giva Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Maritel Status Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Dept. of Public Works 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Walter F. Plummer Lillian M. Hause 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn E. Gordner (Fiance) 578 Pearl St., Rising Sun, Maryland 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Calvary Methodist Cemet. 2/3/00 Churchville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Fecility Tarring-Cargo Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Idiopartic PUL MONARY 763 P Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed Box 68760. the USO as P.O. Division of Vital Records,

page 2 this luneral

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

MD

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours ahar and Meantal Hygiene.

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Department of Health a Important: If Item 27 is any injury or other tra

Physician

/Medical

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Examine

Physician/Medical

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Completed

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Certification: To

edical

t Netural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0020

or Attending Physician: 24 hours after death.

Funeral Director: A filled in by

within 2

Hospital

25

DHMH 16 Ray 6/95

State Registrar

N MANCTIN 31. Dete filed (Month, Day, Year) FEB 1 2000

5 Pending investigation

6 Could not be determined

30. Nama and andress of person who completed cause of death (Item 23a) (Type, Print) 600 NATH 32. Begistrar's Signeture

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

WOIFE

1 Yes 2 No

RES-000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

28l. Location (Street and Number or Rural Route Number, City or Town, State)

JANUARLY

Johns Holkins Hosfital

29d. Date signed (Month, Day, Year)

2000

- making pandancing managements

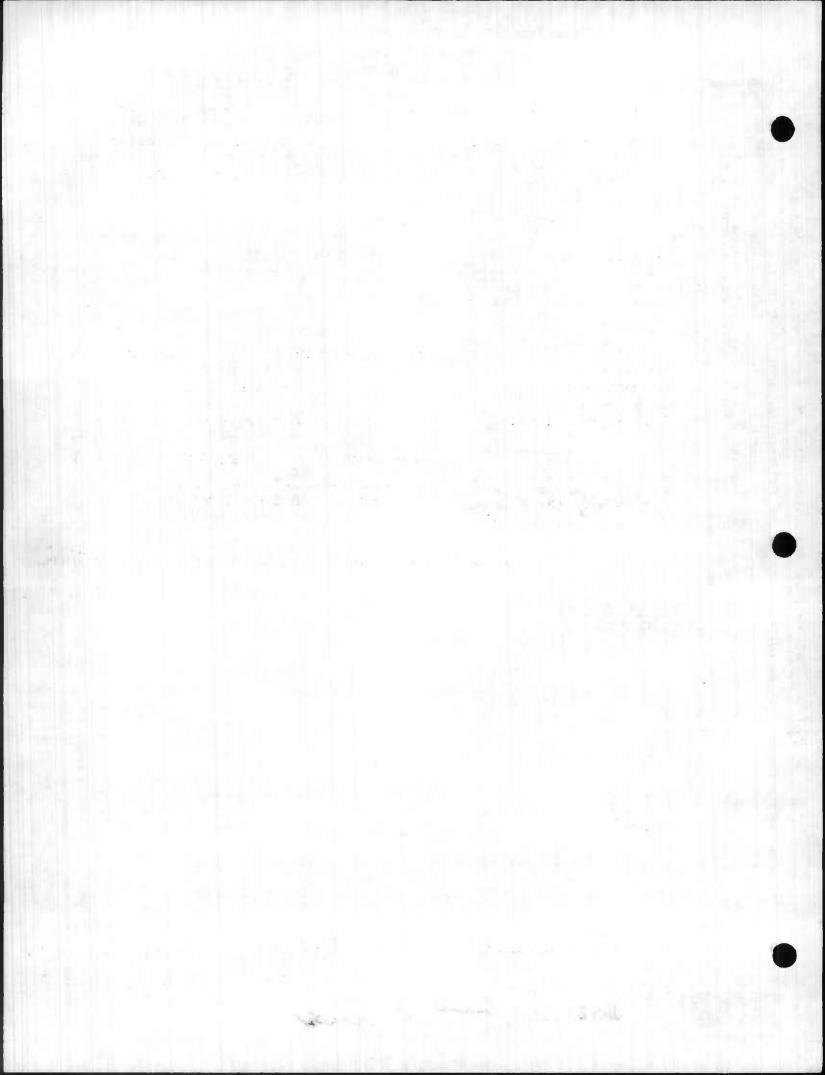
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Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Nama (First, Middle, Last) Day 25, 2000 1010 Month **Physician** January Melville John Paxton, Sr. /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1⊠M 2□ F Yrs 76 1923 Maryland **Director** 219-03-4299 11, Usual Residence of Decedent 10e. Stata 10c. City, Town or Location 10d. Inside City Limits 1 Yes ZONO Directo Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural, or items 23s or the Medical Examiner must be r 306 Irish Lane 21001 U.S.A. Funeral 12. Was Decedant Evar In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian. 11 Marital Status Bleck, White, etc. 1 X Yas 2 No If Yes, Give Yaar or Datas: 1943-50 1 Never Married 257 Married 1 Yes 2 No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completad) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) U.S. Government Civil Engineer Technician 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Surneme) Vincent Paxton Rosalie Winzer 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 306 Irish Lane, Aberdeen, Maryland Hem 27 i Madelle Paxton (Spouse) Saltimore, 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Spacify) Spesutia Cemetery 1/28/00 Perryman, Maryland 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Aberdeen, Maryland 21001-3.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ahock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Myo cardial Infarction /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated avants resulting in death) Lest Due to (or es a consequence of): Physician/Medical Dua to (or as a consequenca of): 88 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other alignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings avelleble prior to 24a. Was en eutopsy performed? Completed completion of causa of deeth? page 2 has 1 Yes 2 No certificate Division of Vital 25. Wes case refarred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes ₽E No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 BNatural funeral 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? Certification: 5 Pending Investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours Medicai 29e. Certifier 1 Cartifying Phyalclan: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) within 2 the 29c. Licensa number 29d. Deta signed (Month, Day, Year) 29b. Signature end title of certifie 2000 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10+1 Manuel 31. Date filed (Month, Day, Yeer) JAN 2 7 State

Registrar

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year 31 2000 Roger Hugh Pierce 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death County Cecil Union Hospital of Cecil 1kton If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1♥ M 2□ F 121-26-8758 66 New York Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 41 Greenhurst Lane 21911 United States 14. Race - American Indian, 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2☐ No Navy If Yes, Give 1964—Year or Dates: 1982 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 1982 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 United States Navy Computer Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter A. Pierce Mary Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Greenhurst Lane, Rising Sun, Maryland 21911 Fern F. Pierce / Spouse 20s. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 4,2000 Rising Sun, Maryland Ebenezer Cemetery 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Fecility Crouch Funeral Home rere 127 South Main Street, North East, Maryland 2190 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) infarction Acute myocardial Due to (or as a consequence of): disease Coronary artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): that initiated events resulting in death) Last Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cerebrovascular accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? hypercholesterolemia 1 Yes 2 No 1 Yes 2 No Diabetes mellitus a ortic value replacement 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 □ Fr/Outpatient 3 ☐ DOA

Examiner physician and the buriel-transit Box 68760. P.O. Records, Division of Vital this

Physician/Medical by Completed Be 2

at or Attending Pt is effer deeth. If Director: After the ed in by the funeral Certification:

Physician

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pernit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Marylan Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than "natural", or flams 23s or 28s-f show eny injury or other traumatic event, the Medical Examinator must be notined as

Physician

/Medical

Examiner

Maryland 21215-0020

Baltimore.

19W

/Medical

To the Hospital of within 24 hours of To the Funeral Discompletely filled in 2+1VA

State

Registrar

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred NA 5 Pending investigation 1 Yes 2 No NA 2 ☐ Accident NIA 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the 29a. Certifier ner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

00050195

29d. Date signed (Month, Day, Year)

February

1,2000

Shanna Marie Pay lorno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 colonial Wax Rising Sun, MD

31. Date filed (Month, Day, Year) FEB 0 2 2000

29b. Signature and title of certifier

32. Registrar's Signature Soorks!

Please Type or Print in Black Indelible Ink. Assure All Conies Are Legible

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| VC.00 | /Medica Examine | _ | 4a Facility Neme (If not institution, give | street and number) | | | 4b. City, Town, or L | ocation of Death | 4c. County of [| Death |
| | - Adminic | " | Manor Care of La | argo | | | Largo | | Prince (| George's |
| | ineral rector | | 579 42 6954 | 7. Age (In yrs. I | last birthday) Yrs. | If Under 1 Yee Months Dey | | 8. Dete of Birth (Month, Day January | 9. 27,1907Ge | Birthplace (State or Foreign Country) Crmany |
| put | 3 | + | Usuet Residenca of Decedent 10a. State 10b. County | 10c. City | y. Town or Loc | ation | | | | 10d. Inside City Limits |
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| the | 2 H | Director | Maryland Prince Ge | eorge's La | irgo | 10f. Zip Code | | 1 | 0g. Citizen of Wha | 4.5 |
| 5-0020 72 hours after death with the Maryland | al', or items 23a or 28a-f show Examiner must be notified at | ٥ | 600 Largo Road | | | | 774 | | USA | |
| leath | 22 | Funeral | 11. Marital Stetus | 12. Wes Decedent Ever in U, | S. 13. W | as Decedent of | Hispanic Origin? (Sp ban, Mexican, Puerto | ecify Yes or No- | 14. Race - | American Indian, |
| fler | | 2 | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 🏋 No | | | | Rican, etc.) | | White, etc. |
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| 6 = | CI b | - | Catherine Studds/ | | | | ok Circle | | | |
| | if item or othe | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F | Removal from State | cametery, crem | ition (Name of atory or other p | face) | Dete | 20c. Location - Cit | y or Town, State |
| Baltim permit. Pag Department | Important: If is any injury or once. | | 4 □ Donation 5 □ Other (Specify) | | dar Hil | 1 Cemet | ery | 1-29-00 | Suitland | , Maryland |
| Balt Pemit. Departr | ny in | | 21. Signature of Funerel Service Licens | 99 | 22. | Name end Add | ress of Facility Mar: | shall's | Funeral 1 | Home of MD |
| u 88. | E # 2 | | Limbol Ber | ones | | | tland Roa | | | |
| /Me Exar | sician edical miner | ner | shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) | a Hyperter Due to to | or es a consequence | Concuence of): | diova | rcula Vas Cu | udisu | Interval Between Onset and Death MC J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Course Man J Cours |
| . BOX 68/60, death certificate be executed | sicle bur | Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | Due to (o | or as a consequ | uence of): | | | | |
| | the at | SIC | Part II. Other significant conditions co | ntributing to death but not res | ulting in the un | derlying cause | given in Pert I. | 23b. Did to | obacco uss contri | buts to the causs of death? |
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| Orc | should | Completed | | | | | | 24a. Was e | | 24b. Were autopsy findings available prior to completion of cause |
| Records, | has by | <u>a</u> | | | | | | | 1 | of death? |
| = = | page page | 50 | | | | | | 1 🗆 Y | es 2000 | 1 ☐ Yes 2 ☐ No |
| Vital | £ 6 | Be | 25. Was case referred to medical examiner? | | | | | ith (Check only or | ne) | |
| - 5 | in in | 2 | 1 ☐ Yes 2 No | | ER/Outpatien | 3LI DOA | | | lenca 8 Other | |
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| | octor: After by the fune | cat | 2 Accident Investigation 3 Sulcide 6 Could not be | | | | ☐ Yes 2☐ No | 38f Location (6 | Street and Number | or Rural Route Number, |
| Or At | Director: | | 4 ☐ Homicide determined | 28e. Place of Injury - At he building, etc. (Specif. | ome, farm, stre | et, factory, offic | a | City or Tow | m, State) | or narar noble reamber, |
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| To the Hospital within 24 hours | To the Funeral Dir completely filled in | 2 | 29b. Signeture end title of certifier | and menner stated. | | 29c. Lice | ense number | | 29d. Date signed (| Month, Day, Year) |
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| 1/1 | | | 30. Neme end eddress of person who c | | | | 1+0 222 D. | ordio MD | | |
| 1111 | | | Rakesh Arora, M.D 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | | Lane Su | Tre ZZZ De | owie, III | | |
| F | State Registra | | FEB 0 2 2000 | De l'inglatiai à Signe | | do - | | | | |

DHMH 16 Rav 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 29 2000 0230 CLAUDE PRATT, SR. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year 8. Date of Birth (Month, Day, Year) April 2, 1916 S. Social Security Number 055-01-2687 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 83 **Director** Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No College Park Directo Maryland Prince George's 28s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20740 3417 Duke Street U.S.A. 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Merital Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by **Black** 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Private 3rd Manager 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be in ment of Health and Mental H ant; if them 27 is marked off lury or other traumatic aven on and Mental 3. Be James E. Pratt Ida F. Raddler 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Olga Pratt/Wife 3417 Duke Street, College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from Stete Department o Important: If any Injury or 2000 George Washington Cemetery Aldelphi, Maryland 4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tritervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) myolandi Examiner Examiner usclustic The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): and Box 68760, Physiclan/Medical thet initiated events resulting in deeth) Last use as the Due to (or es e consequence of): P.0. Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pide unio Division of Vital Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed Cardio Varcular discar 1 ☐ Yes 2 ☐ No woodid tal or Attanding Physician: Tra after death.

at Director: After this certificatied in by the luneral director, p 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, lerm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ HomicIde To the Hospital within 24 hours a To the Funeral Completely filled Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steled. Medical 29e. Certifier (Check only one) 29b. Signature and title of certilier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2090 Dr. Silver Spring DI -67 LUNG 100 32. Registrar's Signature 31. Dete liled (Month, Day, Year) State FEB 0 4 2000

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Registrar

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| Examine | er | 4e. Fecility Neme (If not institution, given National Lu | | | | | 4b. City, Towr Rockv | i, or Location of D i111e | | | | v |
| ineral rector | | 5. Sociel Security Number 6. S | | Age (In yrs. lest b | irthdey) Yrs. | It Under 1 Year Months Days | II Under 24 | Hrs. 8. Date o | Birth Day, Yea | 11) | Birthplece | e (State or Foreign Sylvania |
| | _ | Usuel Residence of Decedent 10a. Stete 10b. County Md. Montgon | erv | 10c. City, Tox | | ation | | | | | | Inside City Limits 1 □Xyes 2 □ No |
| | Funeral Director | 10e. Street end Number 9701- Veirs | | | | 10f. Zip Code 208 | | | | Citizen of Wh | | |
| | þ | 11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Deceder Armed Forces 1 Yes 2 lt Yes, Give Yeer or Detes | s? ₫ No | | | | n? (Specify Yes o Puerto Rican, etc. | r No- | Black, | American I White, etc. | |
| e Medical | To Be Completed | 15. Decedent's Ed (Specify only highest grade) Elementery/Secondery (0-12) | ucation de completed) College (1-40 | | e. Deceder (Give kir life. DC | nt's Usuel Occup nd of work done O NOT use retire | pation during most o | f working | 16b. | Kind of Busin | ness/Indust | lry |
| C event, in | o Be Co | 12 17. Father's Neme (First, Middle, Last) Harry Schleg | er | | Во | okkeep | 18. Mother's | Name (First, Mic nnah Ki | ddle, Maide | | | able |
| other traumatic | | 19a. intorment's Neme/Reletionship (7 Dr. Nathan Price | | 19 | b. Meiling | Address (Street Harbor | end Number o | Dr., A | ot.1 | or Town, St 502-B | ete, Zip Co | , Md. |
| 8 | | 20e. Method of Disposition 1 □ Burlel 2 X X remetion 3 □ 4 □ Donetion 5 □ Other (Specify | | cemete | ery, creme | tion (Neme of tory or other ple tan Cr | | Dete ry-2/1 | | Location - Ci | | Stete ria, Va. |
| any Injury or once. | | 21. Signeture of Funerel Service Licans | ose o | | 22.1 | | Comp | any,Inc | | l- | DO 2 | 0005 |
| sician edical miner | | 23a. Pert 1. Enter the tilease of the shock, or heert failure. List shill disease or condition resulting in deeth) | ications that cause the cause or eech | ed the death. Do line. | not enter | the mode of dyle | ng, such es ca | rdiec or respireto | ry arrest, | dSII., | Ap | Proximate erval Between uset and Deeth |
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| achec | 2 | Pert II. Other eignificant conditions co | ntributing to death | (| in the und | eriying cause giv | en in Pert I. | | Did tobaco | | | cause of death? |
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| rector, page 2 | E | | | | | | | 1 | □Yes | 20 No | 1 🗆 Ye | es 2 No |
| 10 P | 0 | 25. Wes case reterred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth | Hospitel: 1 ☐ Inpai | | utpetient | 3 DOA Oth | er: Nursi | Deeth (Check or | Residenca | 6 Other | | |
| led in by the funeral | meation | Neturel 5 Pending Investigation 3 Sulcide 6 Could not be determined | (Month, D | njury - At home, fe | Injury | M 1 □ | k? Yes 2□No | 28t. Location | on (Street t | and Number | | oute Number, |
| completely filled in by | | 29a. Certifier 1 Certifying Phy | building, e | etc. (Specify) t of my knowledge | e, deeth o | ccurred et the tir | ne, dete end p | iece, end due to | Town, Ste | (s) and menn | er as stete | d. |
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| State Registrai | 7 | FEB 0 4 2000 | 32, Hegis | trer's Signeture | 6 | 1. | | | | | | |

DHMH 16 Rev 6/95

FEB 11 & 2000

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anthony Stanley Pruszenskí 2000 February 2. 10:55 p.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2105 Rolander Street Adelphi If Under 24 Hrs. Prince George's If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F Yrs. Director 193-09-0603 83 January 3,1917 Pennsylvania Usual Residence of Decedent the Meryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or flams 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ♥ Yes 2 No Directo Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with deeth Funeral 2105 Rolander Street 20783 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. e filed within 72 hours efter al Hygiene. other than "natural", or its 1 XYes 2 No If Yes, Give Year or Detes: 1942 1 ☐ Never Merried 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specity: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced - 62 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aeronautical Instructor Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 12 should be fiill and Mental H 2 Joseph Anthony Pruszenski Anna Ulanowiz 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun Irene D. Pruszenski - Wife 2105 Rolander Street, Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/4/2000 Alexandria, Virginia 21. Sepature of Funeral Service Licenses 22. Name end Addresa of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 ROLL 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final Cancer of the Lung disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence ot): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 80 ettending 0 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records. by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? The law 1 Yes 2 No 1 □ Yes 2 □ No certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica Be 25. Was case referred to medical 26. Piace of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 26b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Aocident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 26e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical completely

29c. License number

11701 Livingston Road, #203, Ft. Washington, MD 20744

D19431

29d. Date signed (Month, Dey, Year)

February 3, 2000

State

Frank M. Ryan, 31. Date filed (Month, Dey, Year) FEB 0 4 2000

(Check only one) 29b. Signature and title glass

> 32. Registrer's Signature B. Aprile

30. Name and address of purport who completed cause of death (Item 23a) (Type, Print)

Md.

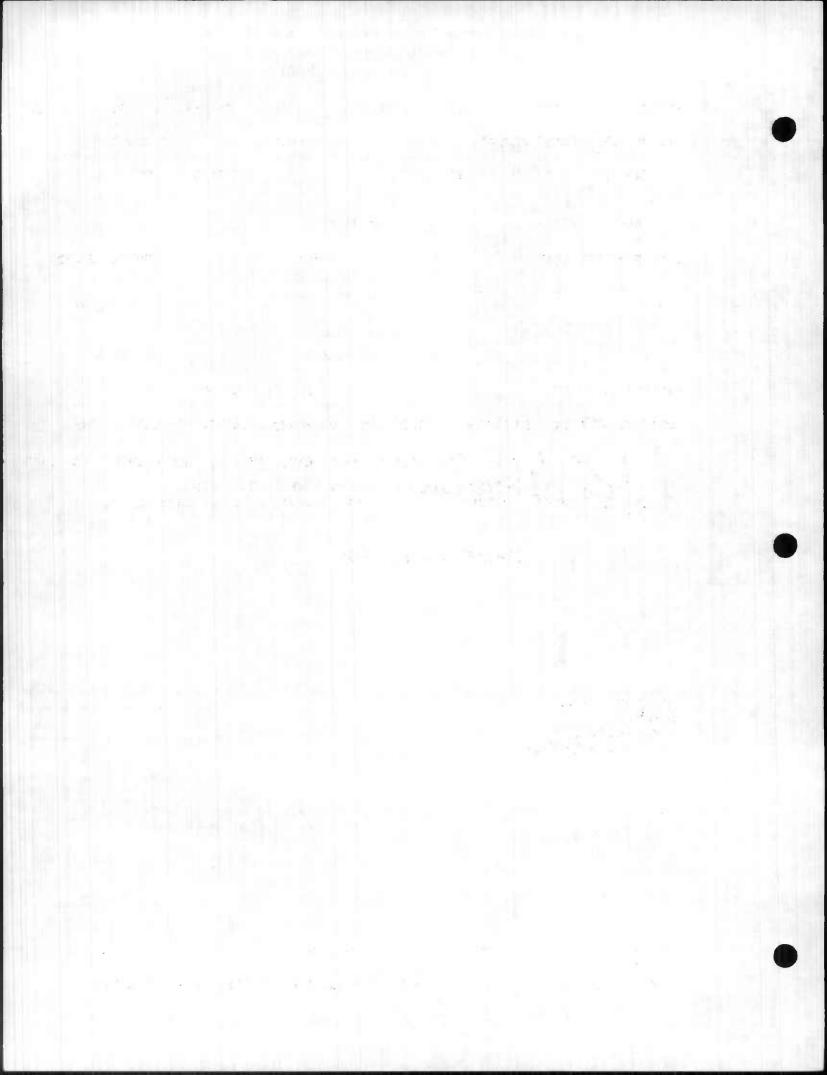
Registrar

FEB 9 4 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | State of | Marylar | | artment rtificate | | | d Mental | Reg. No. | UU | 03233 | | |
|--------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------|-----------------------|------------------|-----------------|-------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------------------|--|--|
| | | 1. Decedent's Neme (First, Middle | , Last) | | | | | | 2. Dete o | | Yeer | 3. Time of Death | | |
| Physicia /Medic | al | ALICE ELIZA 4e Facility Name (If not institution) | | HURTT | PIC | CKERAL | | 4b. Citv. Town. | | LUARY 2, | 2000 ounty of Deat | 1:30 AM | | |
| Examin | er | WALDORF HEALTHC | ARE CENTE | 2 | | H Hadar | | WALDORI | F | CH | ARLES | | | |
| Funeral Director | | 5. Sociel Security Number 212-74-4398 | 6. Sex 1□M XIXF | 92 | last birthday) Yrs. | if Under Months | Deys | | Vin. (Mont) | of Birth Dey, Year) BER 5, 1 | 907 M | hplece (State or Foreig untry) IARYLAND | | |
| show | | Usuei Residence of Decedent 10e. Stete 10b. County | | 10c. Ci | ity, Town or Lo | ocation | | | | | | 10d. Inside City Limits | | |
| ath with the Maryla 23s or 28s-f show | Director | MARYLAND CHAR 10e. Street and Number | LES | | | WALDO | _ | | 10g. Citizen of Whet Country? | | | | | |
| th with | | 2680 HAMILTON R | OAD | | | | 20 | 601 | | | UNITED | STATES | | |
| urs efter de | by Funeral | 11. Meritei Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | 12. Wes Deced Armed Ford and 1 Yes 2 If Yes, Give Yeer or De | ces? 2 ⊠ No | | Wes Decedif Yes, spec | | | ? (Specify Yes o | pecify Yes or No- o Rican, etc.) 14. Rece - American india Bleck, White, etc. Specify: WHITE | | | | |
| od within 72 hours eff giene. In then "neture!", or | Completed | 15. Decedent (Specify only highes | t grede completed) | d) 16a. Decedent's Usuel Occups (Give kind of work done of life. DO NOT use retired, | | | | during most of | working | 16b. Kind | of Business/ | Industry | | |
| filed within Hygiene. ther than | Com | Elementery/Secondary (0-12) | O O | 401 5+) | | HOME | EMAK | ER | | C | WN HOM | IE | | |
| d out | To Be | 17. Fether's Neme (First, Middle, I RAYMOND I. HURT | | | | | | | Name (First, Mi | | imeme) | | | |
| 2 should b end Menti is marked | - | 19e. informent's Neme/Relationsh | | | (Street | | or Rural Route N | | own, Stete, 2 | (ip Code) | | | | |
| | - | DORIS J. WILLET 20e. Method of Disposition | T - DAUGH | 20b. I | Plece of Dispo | sition (Nem | ne of | | WALDORI | - | | ND 20601 n - City or Town, State | | |
| bernit. Peges 1 ar Department of Hear Moortant: If Nem 3 Iny Injury or other | | 1X Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (Sp | 3 Demovel from S | 1010 | cemetery, crer PAUL | | | | FEB. 7, | 2000 W | ALDORE | , MARYLAND | | |
| permit. Pege: Department of Important: If I any Injury or once. | | 21. Signeture of Funera Service L | 101 | ekai | un TF | HE HUN | TT | | L HOME, | | 20604 | | | |
| 100 | 1 | 23a. Pert1. En er the disease, or shock, or heert feilure. List of | | 0053 used the dee | th. Do not ent | o BOX | e of dyl | ng, such es ca | OORF, MA | Ory errest. | 20604 | Approximate interval Between | | |
| Physician /Medical Examiner | Jer | immediate Ceuse (Finel disease or condition resulting in deeth) | e. CORON | | RTERY D | | Ε | | | | 1 | Onset and Deeth | | |
| | Examiner | | | | | | | | | | | | | |
| ficate phy is the | Wedical | Ceuse (Diseese or Injury that initieted events resulting in deeth) Last | C, | Due to (d | or es e conseq | quence of): | | | | | | | | |
| deeth certif e ettending ed for use a | d. | | | | | | | | | | | | | |
| the d | Physician/M | Pert ii. Other significant condition DIABETES - TYP DEMENTIA | | ith but not res | sulting in the u | nderlying ce | euse gi | en in Pert i. | 23b. | | | to the cause of death robably 4 Unknow | | |
| 8 6 8 | Completed by | ATHEROSCLEROSIS PARKINSON'S DIS | | | | | | | | Wes an autops: periormed? | | Were eutopsy findings available prior to completion of ceuse of deeth? | | |
| The lav | Com | | | | | | | | | 1 □ Yes 200 | No | 1 □ Yas 2 □ No | | |
| Physician: The | Be | 25. Wes case referred to medical exeminer? | Hospitei: | | | | Ìœ | | Deeth (Check | - | | | | |
| A SET OF | on: To | 1 🛱 Yes 2 □ No 27. Menner of Death 1 ☐ Neturel 5 □ Pending | 28a. Dete of | | 28b. Time of injury | f 2 | 8c. Inju Wo | ry et rk? | | Residence 6 | | cify) | | |
| To the Hospital or Attending within 24 hours after death of the Funeral Director. After completely filled in by the fune | Certification: | 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi | ot be 28e. Piece of | of Injury - At h g, etc. (Speci | nome, ferm, str | M reet, fectory | | Yes 2 No | 28f. Locat | ion (Street and r Town, Stete) | Number or Ri | ural Route Number, | | |
| To the Hospital within 24 hours a To the Funeral I completely filled | edical | | Physician: To the be examiner: On the bes | sis of examine | | | | | | | | | | |
| within To the comple | × | 29b. Signeture end title of certifier | | | | 29c | . Licen: | se number | | 29d. Dete | signed (Mont | h, Dey, Year) | | |
| ->-0 | | | M. Ta | | MD | |)-50 | 883 | | FEBR | UARY 4 | , 2000 | | |
| | | 30. Name end eddress of person v YAHIA M. TAGOUR | | | | |)AD, | LEONAL | RDTOWN, | MARYLAN | ID 2065 | 50 | | |
| Stat | | 31. Date filed (Month, Day, Year) | | gistrer's Sign | eture | | , | 4 | | | | | | |

DHMH 16 Rev 6/95

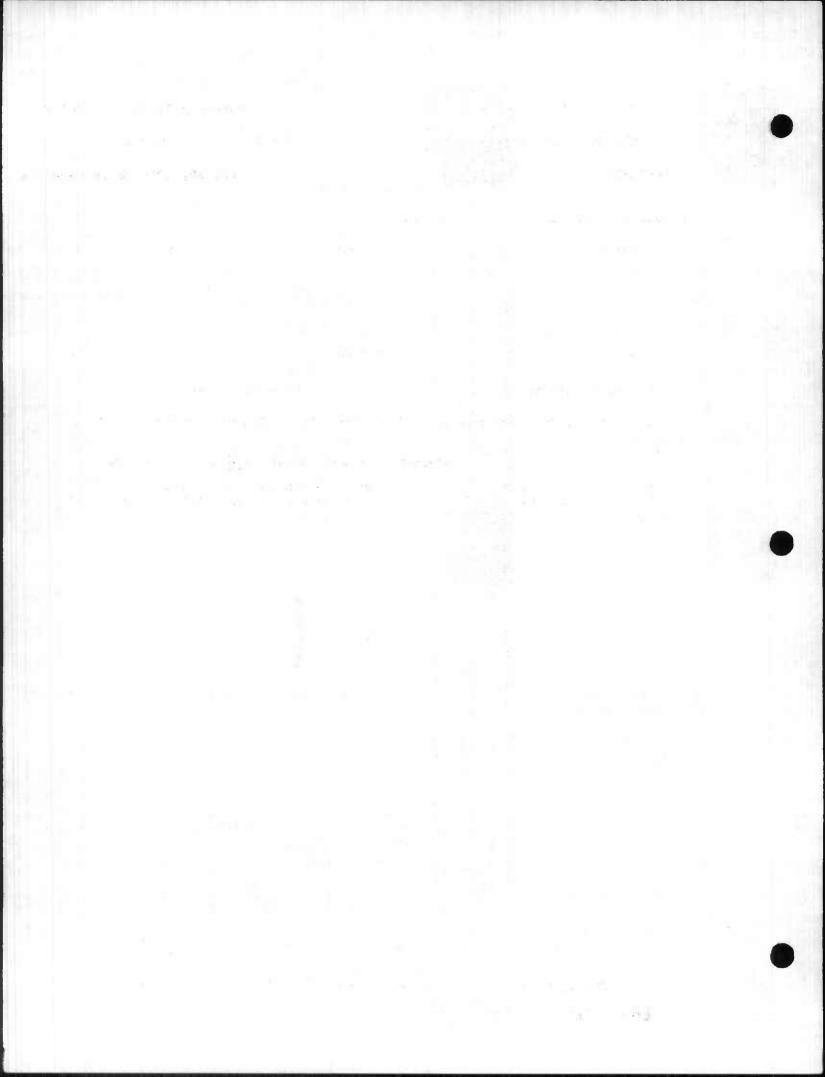


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\cap \)

| | | | | Otato or mi | arylan | | | | Death | | Reg. No. | U; | 523 | 34 | |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------|---------------------------------|-------------------------------------|---------------------------|-------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------|----------------------------------|--|
| | Para de la constant | | 1. Decedent's Nama (First, Middla, Las | t) | | | | | | 2. Data of De Month | ath Day | Yaar | 3. Time | of Death | |
| | Physici /Medic | | Edith E. | Prat | t | | | | | Februa | | | 170 | 1 P | |
| | Examir | | 4a. Facility Nama (If not Institution, give | street and number) | | | | | 4b. City, Town, or I | ocation of Death | 4c. County | of Death | | | |
| | | | Sunbridge Care | Center | | | | | Elkton | | Cec: | il | | | |
| | Funeral Director | | 134-14-2418 | ex 7. Ag □M 2∏7 F | je (In yrs. l | asf birthday) Yrs. | If Unde Months | Days | if Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Dey, Year) July 30, 1914 9. Birthplace (Stefe or Foreign Country) North Carolina | | | | |
| | and * | | Usual Residence of Decedent 10a, State 10b, County | | 10c. City | , Town or Lo | cation | | | | | 10 | Orl inside | City Limits | |
| | the Marylar 28s-f show | ō | Maryland Cecil | | | lkton | | | | | | ' | | es 2 No | |
| | the Mi | Directo | 10e. Street and Number | | | | 106.7 | ip Code | | T | 10g. Citizen of V | What Count | try? | | |
| | eath with | ral Di | 1 Price Drive | | | | | 2192 | | | United | d Sta | tes | | |
| 020 | or iten | by Funeral | 11. Maritat Status 1 □ Nevar Married 2 □ Marriad 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? 1 ☐ Yas 2 ☐ If If Yes, Give Yaar or Dates: | | | | | Ispanic Origin? (Si an, Maxican, Puert Specify: | pecify Yas or No o Rican, etc.) | Specify | ck, White, e | - American Indian, White, etc. White | | |
| 21215-0020 | within 72 hours ene. then *netural*, in Med cal Exc | Completed | 15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12) | ucation de <i>completed)</i> College (1-4or 5 | 5+) | | lent's Usi kind of w DO NOT I | ork done use retire | during most of world) | 16b. Kind of Business/Indust In her own | | | | me | |
| 0 | be filed withintal Hygiene. d other than event, the M | ŭ | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mother's Nan | ne (First, Middle, | | | | 1110 | |
| Maryland | 9 4 4 5 | To Be | George Washing | rton Davis | : | | | | | lice Ha | | , | | | |
| 37 | s 1 and 2 should be f Health and Mental tem 27 is marked other traumatic ev | - | 19a. Informent's Neme/Relationship (7 | · | , | 19b. Meilin | g Addres | s (Street | end Number or Ru | | | Stete, Zip | Code) | | |
| | 1 and 2 Health a em 27 le | | Virginia F. Tr | ostle/Dau | ighte: | r 11 | 9 Ja | rmon | Road, El | kton, M | aryland | 2192 | 1 | | |
| Baltimore, | 80= 6 | | 20a. Method of Disposition 1 | | CE | lace of Dispo | natory or | othar ple | ' | Date FEB | 20c. Location - | | | | |
| | permit. Pa Departmen Important: any Injury | | 4 Donetion 5 Other (Specify) Roselawn Memorial Gardens 7,2000 Princeton, WV | | | | | | | | | | | | |
| Ä | Depar Impor any Ir | | 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter tha disaase, or complications that caused the daath. Do not enter that mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | |
| | | | 23a. Part1. Enter tha disaase, or comp shock, or heart failura. List only of | lications that caused the cause on each li | the daath | . Do not enta | ar tha mo | de of dyi | ng, such as cardiac | or respiratory a | rrest, | | interval I | Between | |
| 9 | Physician /Medicai Examiner | | Immediata Cause (Final disease or condition | Don | rent | ia of | Ala | her | mor ty | pe | | | ye | ass | |
| | Examine | L. | resulting in death) | 0 | Due to (or | as a conseq | uenca of | }: | 0. | | | 1 | | | |
| | b is | nine | | b. ——— | | | | | | | | | | | |
| _ | icate be executed physician and s the burial-transit | edicai Examiner | Sequentially list conditions, if any, leading to immediate | | Due to (or | es a conseq | uence of |): | | | | 1 | | | |
| 68760, | be e siclan buris | a E | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events | c | | | | | - | | | | | | |
| 587 | g physias the t | ba | resulting in death) Last | | Dua to (or | as a conseq | uance of) | 1 | | | | 1 | | | |
| | certifi ding | 900 | | d | | | | | | | | | | | |
| Box | death cer e attendin id for use | clar | | | | | | | | | | | | | |
| P.0. | the d | Physician/N | Part il. Other significant conditions co | ntributing to death b | ut not rasu | iting in the ur | ndertying | cause gi | ven in Part i. | | tobacco usa co | | | - | |
| | that deta | T | | | | | | | | 1 🗆 | Yss 2□ No | 3 ☐ Prob | ably 4 | (L) Onknown | |
| Vital Records, | v requires that the death certific been signed by the attending p should be detached for use as | Completed by | | | | | | | | 24a. Wes | an autopsy prmed? | cor | Illable pri | sy findings or to of cause | |
| Re | sicien: The law certificate has b director, page 2 s | dm | | | | | | | | | | | death? | | |
| m | | e Co | OS Mos anno referred to medical | | | | | | | 10 | | 1 | Yes 2 | 2∐ No | |
| ₹ | Physician: this certific rai director, | 00 | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | | | | Ot Ot | 26. Place of Dea | | | (0) 11 | | | |
| o | this aic | 5.7 | 27. Menner of Death | 1 ☐ inpatie | | ER/Outpatien 28b. Time of | | 28c. Inju Wo | 4 M2 INUISING IT | | dence 6 Oth | | ") | | |
| on | ding th. Afte | tlor | 1 ☑Neturei 5 ☐ Pending 2 ☐ Accident investigation | 28e. Date of Inju (Month, De | y Year) | injury | м | | rk? Yes 2 □ No | | | | | | |
| Division of | or Attending after death. Director: After d in by the fune | Certification: | 3 Suicide 6 Could not be determined | 28e. Placa of Injubulding, etc | ury - At ho c. (Specify | me, farm, stre | et, facto | ry, office | | 28f. Location (. City or Tox | Street end Numb wn, Stete) | er or Rura | Route N | lumber, | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edical C | 29a. Certifler 1 ☐ Certifying Phy (Check only one) | sician: To the best of ner: On the basis of and manner sto | axaminati | vledge, deeth ion and/or inv | occurred | d et the ti n, in my d | me, dete and place opinion, death occu | , and due to the rred at the tima, | cause(s) and ma date and place, | anner as st and dua to | ated. the caus | a(s) | |
| | Mithir Foth | Me | 29b. Signature and title of certifiar | | | | 29 | c. Licen: | sa number | | 29d. Dete signe | | Day, Yea | r) | |
| | ->-0 | | 1 Sant. | clers mi |) | | | 02 | 3322 | | 2/4/2 | 2000 | | | |
| | , | } | 30. Nama and address of person who c | ompleted cause of d | eeth (Item | 23e) (Type | Print) | | | | 7 // | | | | |
| | 5 | | S.S. SARHIDE | VMD. | 1181 | Veerth | 87 8 | rute | 3322 8B. Elk | tonon | 02192 | 1 | | | |
| ľ | Sta | | 31. Date filed (Month, Dey, Year) FFR 0 4 2000 | 32. Registra | ar's Signet | yre | 200 6 | 11 | , | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Yeer **Physician** Mildred Perlitz 20, 2000 0115 Jan /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1□M 2♥ F Yes 87 219-16-1785 Jan 16, 1913 Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or liems 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 74 Conduit Street 21401 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Maritai Stetus permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelih and Mental hyglene. Important: if item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Examinations. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Security Civil Service 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be William Perlitz 2 Frances Sturmer 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Marvin Anderson/ Personal Rep. 92 Franklin Street Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removel from Stete
☐ Donetion 5 ☐ Other (Specify) t. Mary's Cemetery 01-24-00 Annapolis, Maryland 22. Neme and Address of Fecility ture of Funerel Service Licensee John M. TAylor Funeral Home 147 Duke of Gloucester St. Annapolis, Md. 21401 plication, their caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, one cause on each line. Approximele Intervel Between Onset end Deeth **Physician** /Medical Multiport Devention Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner hysician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician certificata be Physician/Medical Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yaa 2 100 3 Probably 4 Unknown to ant intertion þ 24b. Were autopsy findings available prior to Completed 24a. Wes en autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it 5 Pending investigation 1 Meturel
2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of pertified

31. Date filed (Month, Day, Year)

JAN 2 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

alvo

2108

32. Registrer's Signature

DHMH 16 Ray 6/95

29c. License number

1). Umah

032036

Drive Chuke, MD 21615

29d. Date signed (Month, Day, Year) 1/21/00

JAN 8 & 2000 France M. Joseph

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0.05.23.6

| cian | Decedent's Nama (First, Middle, L. | 1th 1/27/2 | 000 00 | ertificate of | | 2. Data of De | | 3. Tima o | Death | |
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| lical | Dolores Ann | Patten | | | | Januar Januar | 00 00 | 7ear 00 4:10 | pm | |
| iner | 4a Facility Name (If not institution, gi | | | | tb. City, Town, or Lo | | | | | |
| щ | | Chesapeake | | | Linthicum | | Anne A | | | |
| | 5. Social Security Number 6. 215-09-8416 Usual Residence of Decedent | 1 M 2 SVE | 975. last birthday 81 Yrs. | Months Days | Hours Min. | 8. Data of Birt (Month, Da Aug 7, | 1918 | 9. Birthplaca (Stata or Fora Country) Maryland | | |
| × | 10a. Stata 10b. County | 10 | c. City, Town or L | ocation | | | | t 0d. Inside C | ity Limits | |
| tor | MD Anne A | rundel | Arnold | | | | | t 🗆 Yes | 2€] No | |
| or than "natural", or items 23s or 28s-7 show it, the Medical Energies must be notified at Completed by Funeral Director | 10e. Street and Number 778 Match Point | Drive | | 10f. Zip Code | 21012 | | | Citizen of What Country? USA | | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S Armed Forces? 1 Yes 2 D No If Yes, Giva Year or Dates: | | r in U,S. 13. | S. 13. Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puarto I t ☐ Yas 2☑ No Specify: | | | Black, | American Indian, Whita, atc. | hita, atc. | |
| | 15. Decedent's E | Education rade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use ratired) | | | 20 | t6b. Kind of Bus | inass/Industry | | |
| 1 | Elementary/Secondary (0-t2) | College (1-4or 5+) | | emaker | 1) | | Home | | | |
| | 17. Father's Nama (First, Middle, Las James Ridgell | it) | | | 18. Mother's Name Lillian | | |) | | |
| 2 | 19a. Informant's Name/Relationship | (Type, Print) | 19h Mail | ing Addrass (Street | and Number or Rura | | | tala, Zip Coda) | | |
| | Carroll Patten | | | - | , Severna | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control | ☐Removal from Stata | 20b. Place of Disp cematary, cre Cedar | osition (Name of ematory or other place Hill Ceme | terv | Date 8 an 25 2000 | 20c. Location - C Brookly | n, MD | | |
| | 21. Signature of Fundral Service Citi | Bar- | В | | ss of Facility Sons, P. | | | | Home 146 | |
| edicai Examiner | Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | bDue | a to (or as a conse | quence of): | np Can | CE C | | 2 m2 |)5- | |
| | Part II. Other significant conditions | dcontributing to death but no | ot rasulting in tha | undarlying causa giv | en in Part I. | 23b. Did | tobacco use conti | ributs to the causs | of death? | |
| ed by the attending detached for use as detached for use as | Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. | | | | | | Yes 2□No | 3 Probably 4 | Unknown | |
| | | | | | | 240 Wee | an autopsy | 24b. Wara autopsy available prior | lo | |
| 2 | | | | | | | med? | completion of of death? | LNo | |
| Be Completed by | 25. Was case referred to medical axaminer | Hospital: | | | 26. Place of Deeth | perfo | ras 2 No | completion of of death? | | |
| in parallellar of | axaminer 1 | he - | | of 28c. Injur Wor M 1 | er: 4 □ Nursing Hor y at 2 k? Yas 2 □ No | perfo | rmed? Yas 2 No Ina) Idence 6 Nothar now injury occurred | completion of of death? 1 Yas 2 Ches Graking General Control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con | mo Home | |
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| edical Certification: To Be Completed by | axaminer 1 | 28a. Data of Injury (Month, Day Ye | At homa, farm, si pecify) y knowledge, deel mination and/or in | of 28c. Injury M 1 1 treet, factory, office | vat 4 Nursing Hory at 47 Yas 2 No | performance of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co | rmed? Yas 2 No Ina) Idence 6 Othar now injury occurred Street and Number vn, Stata) | completion of of death? t | those there | |
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| edical Certification: To Be Completed by | axaminer 1 | 28a. Data of Injury (Month, Day Ye building, etc. (Shysician: To the best of milliner: On the basis of axe and manner steled | 28b. Tima of Injury At homa, farm, stopecify) y knowledge, deel imination and/or in | of 28c. Injury M 1 1 treet, factory, office th occurred at the tirnvastigation, in my o | eer: 4 Nursing Hory at k? Yas 2 No | performance of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co | rmed? Yas 2 No Ina) Idence 6 Othar now injury occurred Street and Number vn, Stata) ceuse(s) and men date and place, and 29d. Data signed | completion of of death? 1 Yas 2 | tho House | |

DHMH 16 Rev 6/95

JAM 27 2005 F 3 WAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G781 3/1/00 va Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Year Month **Physician** PRYOR CHESTER 10 10 January 31 2000 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | Months | Days | Hours | Min. HAGERSTOWN WASHINGTON COUNTY 9. Birthplace (State or Foreign **Funeral** 12 M 20 F 86 Yrs. 3012465 Highfield MI Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No SMITHSBURG WASHINGTON Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13410 KRETSINGER USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, Whita, etc. 1 Yas 2 No 1 Yes, Give 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: WHITE py 3 ☑ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) RAIL ROAD INSPECTOR permit. Pages 1 and 2 should be filled wi Department of Health and Mental Hygien, Important: If Nem 27 is marked other that any Injury or other traumatic event me 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be PRYOR JOSEPH MARGARET FITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) LAURA E WRIGHT KOBINHOOD NORFOLK VA 23513 1DAUG 20b. Place of Disposition (Nama of cemetary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from State 02/04 CASCADE Donation 5 Other (Specify) BETHER CHURCH 22. Name and Address of Facility Grove Funeral Home, Inc 21. Signature of Funeral Sarvice Licensee LIAYNESBORD PA 17268 BROAD Sowersoy 57 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease /Medical Immediata Causa (Final LIND diseasa or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury finat initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 1 No 1 □ Yes 2 □ No or Attending Physician: 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af 1 Yes 2 No investigation 2 Accidant 6 Could not be determined 3 Suicide 28a. Place of Injury - At homa, farm, sfreet, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 🔟 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. edical On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 2-1-00 43570

Registrar

State

Efferson

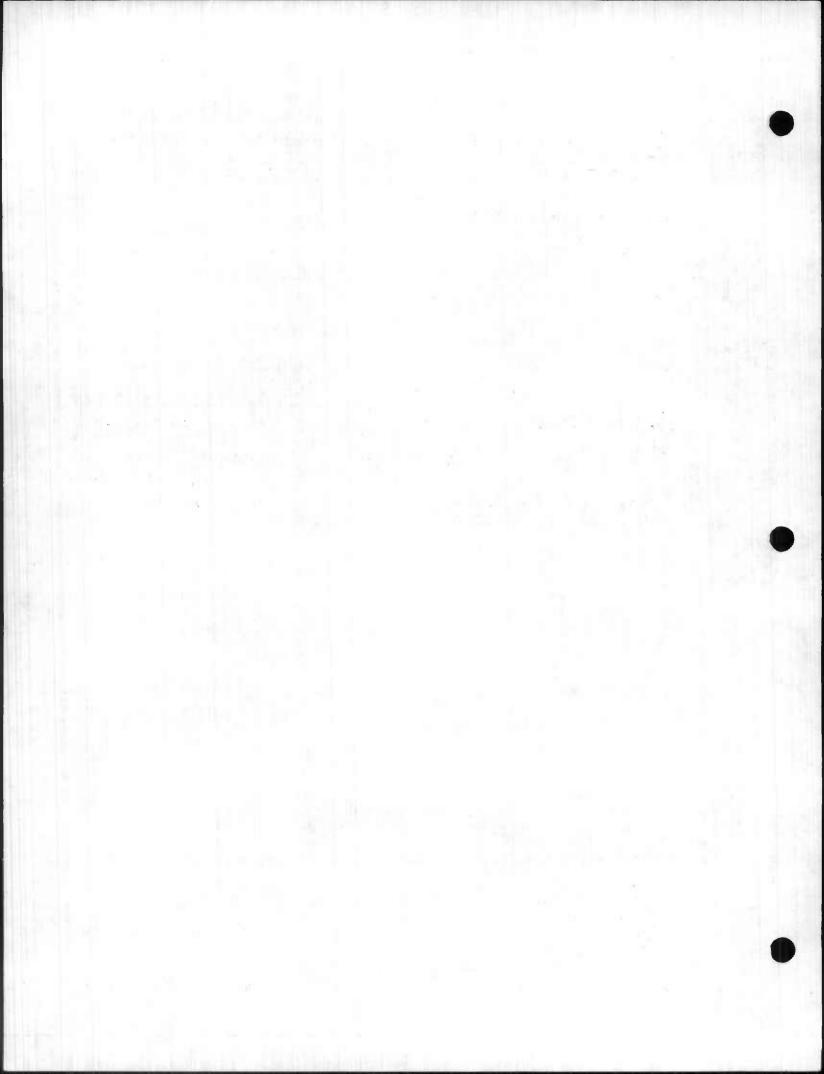
Smithsburg md

and address of person who complated causa of death (Item 23a) (Type, Print)

22911

32. Registrar's Signature

Keed



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 130 AM 4b. City, Town, or Location of Daath slen ff Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Numba 6. Sax 7. Aga (In yrs. last birthday) Days 15M 20 F 57 Yrs 473-46-8448 Dec 19, 1942 New York Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 No Anne Arundel Severna Park 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 368 Sheffield Road 21146 USA 12. Was Decedent Evar in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16h Kind of Rusiness/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Salesperson Computer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Robert Wesley Pfaff Cynthia Kinney 19a. informant's Name/Relationship (Typa, Print) 19b. Malling Address (Straet and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Mary McConnell / wife 368 Sheffield Road, Severna Park, MD 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Feb Data 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory Baltimore, MD 2000 22. Nama and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21 Signatura of Furneral Sarvica Life 495 Gov. Ritchie Hwy., Severna Park, MD Applications and acquise on aach lina. Entar tha disaasa, or com the or heart failura. List only Approximete intarval Between Onsat and Death Immediate Cause (Final disease or condition readiting in death) Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Diseese or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Dfd tobacco use contributa to the cause of death? Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 2 Unknown 1 ☐ Yes 2 ☐ No 24e. Was an autopsy performed? 24b. Wara sutopsy findings available prior to completion of cause of death? 1 Yas 2 DINO t□Yas 2□ No 25. Was casa rafarrad to medical exeptinar? 1 ✓ Yes 2 ☐ No 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3M DOA 28e. Date of injury (Month, Day Year) 27. Manner of Daath 28d. Dascribe how injury occurred 28c. fnjury at Work? 5 Panding Investigation 1 Neturei

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

p

Completed

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Funeral

Director

7 is marked other than "natural", or flams 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Haelth and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic avant, the Medical Experiment must ence.

and 21215-0020

Baltimore.

with the Maryland

Physician/Medical Examiner physician and s the burial-transit 88 usa fo signed by the a should b has

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Certification:

edical

2 Accident

4 Homicida

(Check only one)

3 ☐ Sulcida

29a. Cartifiar

The law requires that the death cartificate be axecuted 68760 Division of Vital Records, P.O. Box is certificata ha or Attanding Physician: this Aftar n 24 hours after death.

Ne Funeral Director: Al plataly filled in by tha fu death. complataly

> State Registrar

29b. Signature and titla of cartifian

6 ☐ Could not be

29c. Licansa number

Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

1 Yes

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 2000

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

pletad causa of daath (kam 23a) (Typa, Print) Jeffrey Briggs MD

2 No

31. Data filad (Month, Day) Year) FEB 0 2 2000 32. Degistrar's Signetura

28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

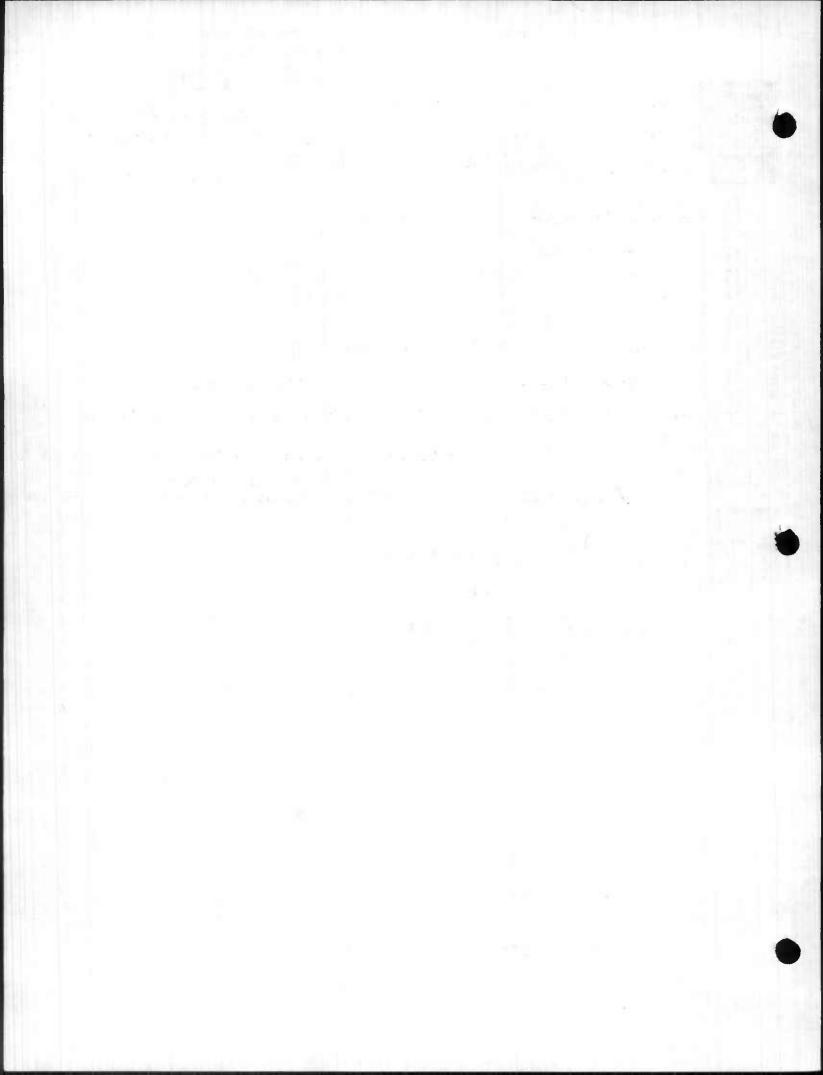
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|---|-------------------------------------------------------------|------|---|---|---|
| | State of Maryland / Department of Health and Mental Hygiene | 0 | 2 | 3 | 0 |
| | 0 110 1 10 11 | | | | |

| | | | | , | | Certificate | of Death | | Reg. No. | | 40.0 | |
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| d | Physici /Medi | | Margaret | | Pete | rsen | | | 28, 200 | | 3:00pm | |
| 1 | Examir | | 4a. Fecility Nama (If not institution, gi Avalon Manor | | | | 4b. City, Town, Hagersto | or Location of Death | 4c. County | | on | |
| | Funeral Director | | | Sex 7. Age (In 1 | yrs. last birth | nday) If Under 1 Months (| | fin. (Month, Da | | | ece (Stete or Foreign | |
| | pu . | | Usuel Residence of Decedent 10a. Steta 10b. County | 10 | a City Town | or Location | April 28, 1916 Virginia | | | | | |
| | e Marylai Ba-f ehow | ector | Maryland Washing | | | erstown | | | | 10 | od. Inside City Limits ↑ Yes 2 No | |
| | h with the | | 10e. Street and Number 1161 Woodland Way 21740 | | | | | | 10g. Citizan of V United | | , | |
| 21215-0020 | be filed within 72 hours after death with the Maryland hat Hygiens. did other than "natural", or Nems 23s or 28s-f show event, the Medical Exertee must be negliged. | by Funeral Director | 11. Maritel Status 1 ☐ Navar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Ever Armed Forcas? 1 Yes 2 No If Yas, Give A Yeer or Detes: | in U,S. | 13. Was Deceder If Yes, specify 1 ☐ Yes 2 ☐ | nt of Hispanic Origin? Cuben, Mexican, Pu PNo Specify: | ' (Specify Yes or No Jerto Rican, atc.) | - 14. Rac Bled Specify | a - America ck, White, a Whit | itc. | |
| 5-0 | 72 ho | eted | 15. Decedent's E (Specify only highest gr | ducation eda completed) | 1 (| Decedent's Usuel (Give kind of work | done during most of | working | 16b. Kind of Bu | usiness/Ind | ustry | |
| 121 | within ena. | mpi | Elementery/Secondery (0-12) | College (1-4or 5+) | | iile. DO NOT use omemaker | retired) | | Hero | 15.773 | | |
| 9 | Hygie Ther ont, II | ပိ | 17. Fether's Nema (First, Middle, Las | t) | | - Cincinarez | 18. Mother's I | Neme (First, Middle, | | | | |
| lan | should be filed withing and Mental Hygiena. • marked other than umatic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Menta | To Be Completed | Joseph G. Coff | ield | | | | eth Pebwo | | | | |
| Mary | nd 2 shou lith and M 27 ie mar r traumat | | 19e. Informent's Na <i>me</i> /Reletionship Holloman-Brown Fu | | 19b. 656 | Mailing Address (S 8 Indian | Street and Number or River Roa | Rural Route Numbered, Virgin | er, City or Town, nia Beac | Stete, Zip | Code) 23464 Lrginia | |
| Baltimore, Maryland | permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is marked eny Injury or other traumatic evonce. | | 20a. Method of Disposition 1 🖾 Burial 2 □ Cramation 3 [4 □ Donetion 5 □ Other (Speci | Removei from State | cematary | Disposition (Neme crematory or other n Memori | r piece) | Dete 52-1-2000 | 20c. Location - Virgini | | wn, State | |
| Balti | permit. Departmimporta eny Inju | | 21. Signature of Funeral Service Lica | | | | Address of Facility William R | Minnich I | | | vland 21740 | |
| | | | 23e. Perf1. Enter the disease, or con shock, or haert feilure. List only | | death. Do no | | | | | nar | Approximate Interval Between | |
| | Physician /Medical Examiner | - | Immediate Cause (Finel disease or condition resulting in death) | · PNE | UMON | | | | | | Onset and Deeth | |
| | ted nsit | nlne | | b. 5205 | _ | | | | | | | |
| 68760, | death certificate be executed e attending physiclan and of for use as the burial-transit | edical Examiner | Sequentially llst conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieled events resulting in deeth) Lest | . DEHYD | RATIC | onsequence of): O U onsequenca of): | | | | | | |
| Box 6 | | ~ | L | d | | | | | | | | |
| P.0. | requires that the daath ce seen signed by the attendi should be detached for use | by Physic | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | 23b. Did tobacco use contributa to the cause of d | | | |
| Records, | 2 S | Completed b | | | | | | | en eutopsy rmed? | eve | re autopsy findings ilable prior to apletion of cause eeth? | |
| <u>=</u> | The age | Con | | | | | | 10 | res 2 KΩ No | 1 🗆 | Yes 2 No | |
| Vita | Physician: Th this certificate ral director, par | Be | 25. Wes case referred to medical exeminer? | Hospitel: | | | | Deeth (Check only o | nne) | | | |
| | this al di | : To | 1 ☐ Yes 25kNo 27. Menner of Deeth | 1 ☐ Inpatient | 2 ER/Outp | | | g Home 5 ☐ Resid | denca 6 Other | |) | |
| O | Attending F r death. ector: After by the funer | tion | 1 Naturel 5 Pending 2 Accident investigation | (Month, Dey Yea | | ury | Injury et Work? 1 ☐ Yes 2 ☐ No | 200. 00001100 1 | TOW IIIJUTY COOLIT | 00 | | |
| Division of | 7 5 5 C | Certification: | 3 Sulcide 6 Could not be determined | 00 - 710 | At home, ferr | m, street, fectory, o | ffice | Yes 2 No 28f. Location (Street end Number or Rurel Route N City or Town, State) | | | Route Number, | |
| | To the Hospital of within 24 hours all To the Funeral D completely filled in | edical C | 29e. Certifier 15 Certifying Pi | nyalcian: To the best of my minar: On the basis of exa end menner stated. | knowledge, minetion end/ | death occurred et l or investigetion, in | he time, dete end ple my opinion, deeth o | eca, and due to the courred et the time, | cause(s) end me date end plece, e | nner es ste end due to | ated. the cause(s) | |
| | To th Withir To th comp | Me | 29b. Signeture and title of certifier | | | 29c. L | Icansa number | | 29d. Date signed | d (Month, E | Dey, Year) | |
| | | | min | To the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the | | (2. | 52322 | | 1/291 | 100 | | |
| | | | 30. Neme end eddress of person who | completed cause of deeth | (Item 23e) (T | ype, Print) | | 0 | , | , | 21746 | |
| | | | 17holid We | iscem, | 186 | 01 190 | xbury | Kd. H | agers | tow | n, mo | |
| | Sta Registr | - | 31. Dete filed (Month, Day, Year) FEB 0 3 2 | 32. Registrer's S | - | G. An | an V. | | 0 | | 21746 21746 M, MD | |
| | | | 1 1 0 0 0 2 | 000 | | - Jujul | -crs | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 24, 2000 Dorothy Pfeil 11:35PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year)

June 15, 1921 Florida 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** 10 M ZZ F Days Months Hours 579-18-0823 78 Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits S Pos 1 □ Yes 2 PHO Director Maryland Prince George's Morningside 28a-f the Medical Examiner must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? harns 23a or 6502 Randol ph Road

12. Was Decedent Ever in U.S.
Armed Forces?

1 | Yes 2D No
If Yes, Give
Year or Detes: U.S.A. Funeral 20746 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Merried 2 Merried specify: White 8 1 Yes 2 No Specify à 3 ☐ Widowed 4 Ox Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince George's Co. al Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Public Schools 10th 17. Father's Neme (First, Middle, Last) N/A 18. Mother's Name (First, Middle, Maiden Sumeme) 88 h and Mental h Alexander T. Recher Elizabeth G. McDonald 10 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 9131 6th Street Lanham, Maryland 20706 19e. Informent's Neme/Reletionship (Type, Print) of Health a If hem 27 is or other tra-Nancy MacWelch 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 126 Pate 20c. Location - City or Town, Stete Department in Lee Crematory Clinton, Maryland 2000 4 ☐ Donation 5 ☐ Other (Specify) Lee Funeral Home, Inc. 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility 6633 Old Alexandria Ferry Road Clinton, MD20735 Hee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final my tacs diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2□ No 3 Probably 4 Unknown þ should I 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? N/A this certificata has 1□ Yes 2 No Putensmil 12164 1 Tyes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Tyes 2 No 2 Accident Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Physician: The law requires that the death certificate be asscuted Division of Vital Records, P.O.

Box 68760.

hours after

be filed within 72

Pages 1 and 2 should nent of Health and Men

21215-0020

Maryland

Baltimore,

To the Hospitat within 24 hours a To the Funeral Completely filled 0

Hospitat

edical

1enn 31. Date filed (Month, Day, Year) State FEB 0 1 2000 Registrar

29a. Cartifier

(Check only one)

295. Signature and office of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Conner M

1450 32, Registrar's Signeture

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29c. License number

720824

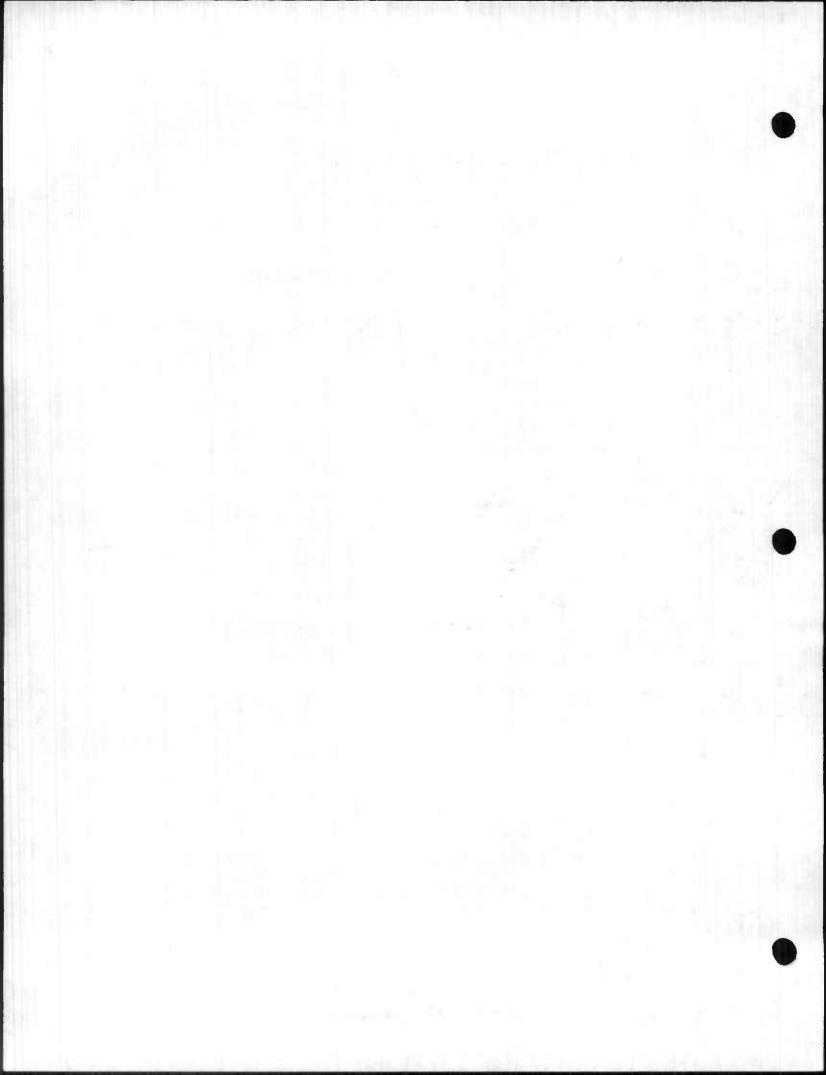
29d. Date signed (Month, Day, Year)

FER # 1 2000

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 524

| | | | | | | Certific | ate of | Death | | Re | g. No. | 00 | () | |
|------------|-----------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------|---------------|-------------|--------------------------------------------|---------------|---------------------------------------|---------------------------------------------|--|
| | | | 1. Decedent's Name (First, Middle, La | st) | | | | | | 2. Date of Death Month | Davi | Year | 3. Time of Death | |
| | Physicia /Medic | | RICHARD | NELS | ON | | RO | DGERS | S | FEBRUAR | Y 1, | 2000 | 1217pm | |
| | Examin | | 4a Facility Neme (If not Institution, given | re street and number) | | | 4 | ib. City, To | wn, or Lo | cation of Death | 4c. County | of Death | | |
| | | | Calvert Memori | al Hospit | al | | E | rinc | e F | rederio | k | Calve | ert | |
| | Funeral | | | | In yrs. last birt | hday) If U | nder 1 Year ths Days | | | | | Birthplace (State or Foreign Country) | | |
| | Director | | 579-48-9825 | 1 X M 2□ F | 67 | rs. | | | | Dec. 9, | 1932 | | D.C. | |
| | De . | | Usuel Residence of Decedent 10a. State 10b. County | 11 | Oc. City, Town | or I postino | | | | 10d. Inside City Limits | | | | |
| | aho a | 2 | | | | | | | | | | 100 | 1 Yes 2 No | |
| | N of | Director | MD Calve | ert | Sun | derla | | | | 140 | X | | | |
| | 5 6 | | 10e. Street and Number | T | | 101 | . Zip Code | 2060 | | 10g. Citizen of What Country? | | | | |
| | ier death with the Marylan Rems 23a or 28s-f show Decimals be notified at | Funeral | 5740 Highland Lane 2068 11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori | | | | | | | eit. Van er No | 14 Pag | US 2 se - American | | |
| | ter de | 5 | 11. Merital Status 1 ☐ Never Married 2 ☑ Married | Armed Forces? | er in U,S. | If Yes, | specify Cubs | in, Mexican | , Puerto I | city Yes or No- Rican, etc.) | | ck, White, at | | |
| 20 | P. P. | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: 1 9 | 53-55 | 1 □ Y∈ | s 2 No | Specify: | | | Specify | white | | |
| 21215-0020 | 72 hours after death with the Maryland "natural", or flems 23s or 28s-f show after Example: mark by notified at | 8 | 15. Decedent's E | | | Decedent's | Usual Occup | ation | | 1 | 6b. Kind of B | | | |
| 215 | in 7 | Completed | (Specify only highest gr | ade completed) | | (Give kind o | f work done ()T use retired | during most | t of workii | ng | | | | |
| 217 | s within jens. T then | E | Elementary/Secondary (0-12) | College (1-4or 5+) | ca | rtogra | apher | | | F | ed. Gv | t. mar | agency | |
| B | be filed ital Hygi d other event, t | Be C | 17. Father's Name (First, Middle, Last |) | | | | 18. Mothe | r's Name | (First, Middle, M. | aiden Suman | ne) | | |
| iar | Mental Mental arked o | 0 | Henry David I | Rodgers | | | | Cath | erine | e Marga | ret D | iCame] | llo | |
| Maryland | 2 should and Men la marke aumatic | | 19e. Informent's Name/Relationship | Type, Print) | 19b. | Mailing Add | ress (Street | and Numbe | er or Rura | l Route Number, | City or Town, | State, Zip C | ode) | |
| | DEAD | | Gay A. Rodgers, | wife | sa | me as | # 10 | above | | | | | | |
| Baitimore, | 272 | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ | | 20b. Place of cemeter | Disposition , crematory | (Name of or other place | ce) | | Date 2 | Oc. Location | City or Town | n, State | |
| Ē | 0 = - 0 | | 4 Donation 5 Other (Special | | So. Me | emoria | l Gard | lens | 02 | -05-00 E | unkirk | , MD | | |
| ait | Separtment mportant any Injury | ı | 21. Signature of Funeral Service Lice | nsee | | 22. Nam | e and Addres | ss of Facilit | у | | | | | |
| m | 20 = 2 8 | | 7/ Illiam F | 2. 3. | | Raus | sch Fu | neral | Home | e, P.A., | Owin | gs, MI | 20736 | |
| | | | 23a. Part1. Enter the disease, or comshock, or heart feiture. List only | plications that caused th | e death. Don | ot enter the | mode of dyin | g, such es | cardiac o | or respiratory arres | st, | | Approximate ntervat Between | |
| 1 | Physician | | Sitton, or front foliate. List only | One cause on seci inte. | | | | | | | | 1 6 | Onset and Death | |
| | /Medical | | Immediate Cause (Finet disease or condition | . Sudder | . 1 | ONIL |) | | | | | Į. | | |
| Н | Examiner | | resulting in death) | | ue to (or as a c | consequence | of): | | 9 | | - | 1 | | |
| ь | P 7 | ine | | Poss | tral | , at | mls | Man | no | U | | į | | |
| | rtificate be executed ng physician and as the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | e to (or as a c | onsequence | of): | | | 1 | - | 1 | | |
| 60 | ician buria | S | Cause (Disease or injury | · agram | red | Car | ena | 25 | ant | ern d | nsen | 20 | | |
| 68760, | phys the | 용 | that initiated events resulting in death) Last | Du | e to (or as a c | onsequence | of): | | | | | 1 | | |
| | 8 9 | 5 | | d | | | | | | | | <u> </u> | | |
| Box | to the | Physician/ | | | | | | | | | / | | | |
| P.O. | the the | S/L | Part II. Other significant conditions of | contributing to death but r | not resulting in | the underly | ng cause gw | en in Part I. | | / | | | the cause of death? | |
| | | | | | | | | | | 1 1 1 Ye | 8 2□ No | 3 Probe | ibly 4 Unknown | |
| ds, | requires een sigr hould be | d by | | | | | | | | 24a. Wes an | autopsy | 24b. Wer | e autopsy lindings | |
| 00 | v require been sign | lete | | | | | | | | perform | ed? | com | lable prior to pletion of cause eath? | |
| Record | has pe 2 | Completed | | | | | | | | 4 Cl V- | 057010 | | | |
| a | ician: The li certificate hi rector, page | | 25. Was case referred to medical | | | | | OC Disease | of Dooth | 1 Yes | | 10 | Yes 2 No | |
| Vital | | To Be | examiner? | Hospitat: 1 ☐ Inpatient | 2 NERVOU | Instient 3 | DOA Oth | or | | n <i>(Check only one</i> me 5 ☐ Resider | | nes (Snerihi) | | |
| ō | r this aral d | 늘 | 27. Manngoof Death | 28a. Date of Injury (Month, Day Y | | ime of | 28c. Injur | | | 28d. Describe hor | | | 1 1 | |
| lon | Attending P ir death. betor: Aftert by the funeri | at lo | 1 Lanetural 5 ☐ Pending investigation | | rear) Ir | njury M | | k7 Yes 2∐1 | No | | | | | |
| Division | or Attendil after death. Director: A in by the fu | E C | 3 Suicide 6 Could not be determined | 289. Place of Injury | - At home, fe | m, street, fe | ctory, office | | 1 | 28f. Location (Str. City or Town, | et and Numi | ber or Rural i | Route Number, | |
| ō | a after | Certification: | Tiomade | building, etc. (| Specify) | | | | | City of FOWN, | State) | | | |
| | To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b | | | ysician: To the best of n | | | | | | | | | | |
| | the H the Fi | ledical | one) | and menner stete | | an wasadg | | | or occurr | | | | | |
| | With To To | Σ | 29b. Signature and title of certifier | 2 | | | 29c. Licens | e number | | | d. Date signe | | ay, Year) | |
| | | | Tromas | e dos | sdan | | D17 | 7168 | | 21: | 2/20 | 000 | | |
| 16 | XJA. | | 30. Name and address of person who | | | | | | | 00655 | | | | |
| | 14. | | KIOUMARCE S | | and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t | HUNTI | NGTOV | VN, M | 1D | 20639 | | | | |
| | Stat | _ | FEB 0 4 2000 | 32. Registrer's | s Signeture | An | uh | | | | | | | |
| | Registra | 21 | LD U # CUUU | 1 | - | 1000 | The same | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** William 31, 2000 4c. County of Deeth 12:25 p.m. Worthington Raley January. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) **Examiner** St. Mary's Home for The Elderly Leonardtown
If Under 24 Hrs. 8. [St. Mary's If Under 1 Yeer Birthplece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Min 1**₽**M 2□ F Months Deys Hours Yrs Director 169-20-6786 86 Nov. 18, 1913 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examiner must be notified an once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland St. Mary's Leonardtown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 22680 Cedar Lane Court 20650 United States
14. Race - American Indian, Funeral 11. Maritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify py 3 ₩Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Clerical Electrical Distributer 18. Mother's Neme (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Be Lewis G. Raley P Bertha Clarke 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zlp Code) 19e. Informent's Neme/Relationship (Type, Print) 24780 Marva Point Way, Hollywood, MD 20636 Mary Ruth Raley / Niece 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) St. Michael's Cemetery 2-3-00 Ridge, Maryland 21. Signature of Euneral Service Liphe 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. dward N. Brins ield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physiclan** Immediate Ceuse (Finel disease or condition resulting in death) /Medical MYOGARDIAL THEARCTION Examiner Due to (or es a consequence of): Examiner physician and s the burial-transit The lew requires that the death certificate be executed Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) 80 attending use o ò signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown PROSTATIZ CANCAR Division of Vital Records, py 24b. Were eutopsy findings available prior to completion of cause of death? should b 24e. Wes an autopsy Completed URINARY TRACT (NERCTION certificate has b lirector, pege 2 s CLAUCONS 1 ☐ Yes 2 ☐ No 1 Yea 2 No ospital or Attending Physician: hours after death. uneral Director: After this certifics sly filled in by the funeral director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28d. Describe how Injury occurred 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Netural 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in 24 hour. the Funeral Director 4 Homicide 29a. Certifier Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) and manner es stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 00 Dennis

8 1

State

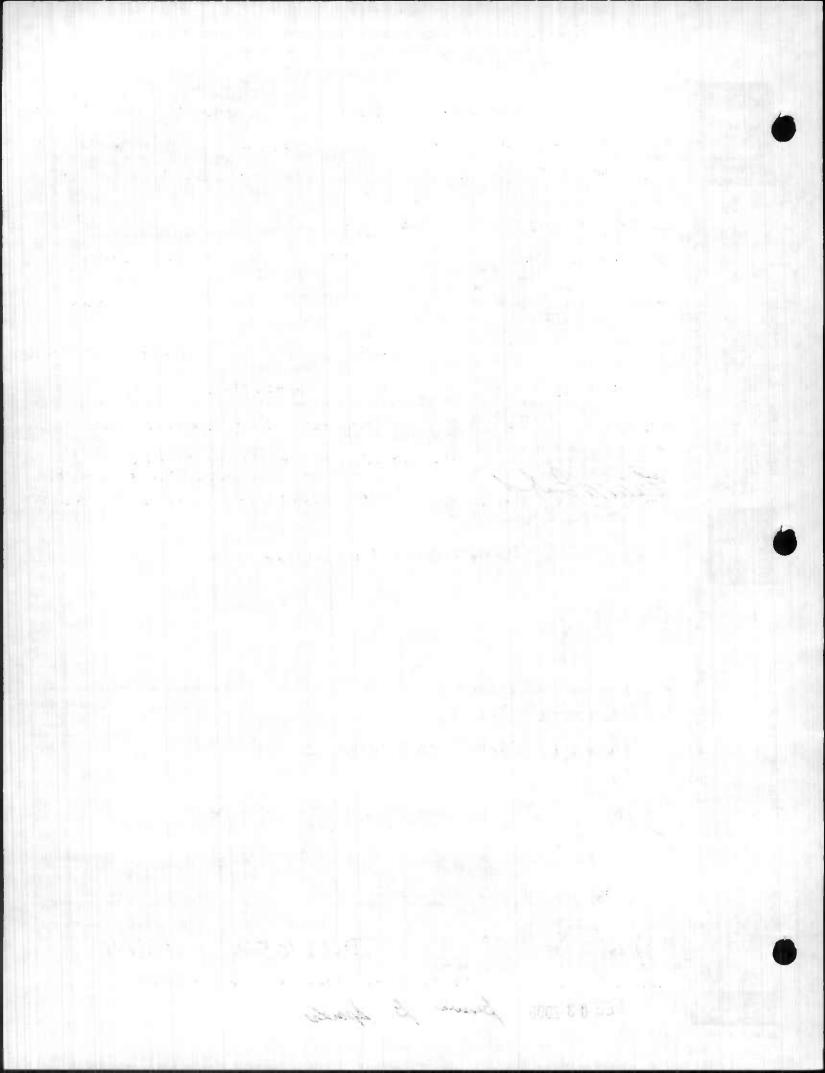
Registrar

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) John L. Bennett, M.D., 23263 By The Mill Road, California, MD 20619

31. Dete filed (Month, Dey, Year) FEB 0 3 2000

32. Registrer's Signeture Lever

oaks



| Cortrado Ma | arrarat | Poveregase | ype or Print in Black indelible ink. Assure All Copie | s Are Legible | |
|-------------|---------|------------|-------------------------------------------------------|---------------|-------|
| sertrade Mo | irgaret | ROYSCOII | State of Maryland / Department of Health and Mental H | ygiene () | 05243 |
| | | | Certificate of Death | Rea. No. | |

| | | | | Cei | rtificate d | of Death | | R | eg. No. | | |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------|--------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------|----------------------------------|-------------|------------------------------------------|
| Physician | 1. Decedent's Name (First, Mid | | | | | | | Date of Dea Month | Day | Year | 3. Time of Death |
| /Medical | GERTI | RUDE 1 | MARGAR | ET | ROYS | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | Januar | y 31 | 2000 | 04:06 P.M |
| Examiner | 4a Fscility Name (If not instituti | | | , | | 4b. City, Tov | | | 4c. County | | |
| · | | Baldwin M: | | | If Under 1 Ye | Fores | | | | larfo | |
| Funeral | 5. Sociel Security Number 376–18–9199 | 6. Sex 7. | Age (In yrs. las | Yrs. | Months Da | | Min. | Date of Birth (Month, Day | (Year) 923 | Coun | laca (Stata or Foraign try) Chigan |
| Director | Usual Residence of Decedent | | 10 | | | | | / (/ 1 | 76) | LIT | siiigan |
| W 18 | 10a. Stefe 10b. Count | У | 10c. City, | Town or Lo | ocation | | | | | 1 | Od. Inside City Limits |
| to the | MD. H | Harford | | | | Fore: | st Hi | Hill 10Y | | | 1 ☐ Yes 2 No |
| tems 23a or 28a-f shon net must be notified at uneral Director | 10e. Street and Number | | | | 10f. Zip Cod | e | | 10g. Citizen of What Country? | | | itry? |
| | 1819 Balo | dwin Mill | Road | | | 210 | 050 | | I | J.S.A | 1. |
| Koer must | 11. Merifel Status | 12. Wes Decede | es? | 13. | Was Decedent If Yes, specify (| of Hispanic Orig Juban, Mexican, | in? (Specify Puerto Rica | Yes or No- an, etc.) | | e - Americ | |
| II. | 1 Never Married 2 Me | Marie Otion | | | 1□ Yes 20 | | | | Specif | Vi TaFla e | . + 0 |
| d by | 3 AWidowed 4 □ Divorce | | | 10. 5 | 4 | | | | ACL KIND A D | Wh: | |
| Completed | | ent's Education ast grada completed) | | (Give | dent's Usual Oc kind of work do DO NOT usa re | na during most | of working | | 16b. Kind of B | usiness/inc | dustry |
| dwo | Elementary/Secondary (0-12) | College (1-4 | | | h Pres | | rator | 3 | Mani | foot | turing |
| | 17. Father's Name (First, Middle | n, Last) | | Lanc | n 11 cc | 1 | | | Maiden Suman | | our THE |
| To Be | William | | | Yerk | e | | Ther | esa. | | p- | ilaske |
| - | 19a. Informant's Name/Relation | nship (Type, Print) | | | | eet and Number | | | r, City or Town, | - | Coda) 21050 |
| | Nancy Y. Full | Lmer/Execu | | | | vin Mi | | | | | ll. Md. |
| | 20a. Method of Disposition | | 20b. Plac | ca of Dispo | osition (Nama o matory or othar | f | 2/ | | 20c. Location | City or To | wn, State |
| | 1 Buriel 2 Cremetion 4 Donation 5 Other | | ete | | | | | | Hampst | cead | Marylan |
| any inju | 21. Signature of Enteral Service Licenses 22. Name and Address of Facility 23. Name and Address of Facility 24. G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland | | | | | | | | | | |
| | 23a. Part1. Enter the disease, shock, or heart failure. Li | or complications that cau | ised the leath. | Do not ent | ter the mode of | dying, such es | cardiac or re | spiratory arr | est, | 1 | Approximate |
| sician | snock, or heart failure. Lis | st only one ceuse on eet | an line | | | | | | | | Interval Between Onset and Deeth |
| lical = | Immediate Cause (Final disease or condition | | 11/1 | ILTINI | E IN | URIES | | | | | |
| iner | resulting in death) | Θ | Due to (or e | s a consec | | -/-(-) | | 12. | | - | |
| in a | N 100 100 100 100 100 100 100 100 100 10 | - h | | | | | | | | - | |
| the bunal-transit | Sequentially list conditions, | | Due to (or a | is a consec | quenca of): | | | | | - | |
| <u>m</u> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | . c | | | | | | | | | |
| edical | fhet initieted events resulting in death) Last | | Due to (or a | s a conseq | quence of): | | | | | i | |
| ¥ . | | d | | | | | | | | | |
| 8 | | | | | | | | | | | 44000 |
| Physician | Part II. Other algniffcant condit | ions contributing to deal | in but not result | ing in the u | indenying cause | gwen in Part I. | | | 1 | 3 Pro | the causs of death? |
| by PI | | | | | | | | 1 U Y | 2010 | 30,710 | bably 4 Dikilowii |
| should be det | | | | | | | | 24a. Was a | | | ere autopsy findings ailable prior to |
| Completed | | | | | | | | perfor | med / | co | mpletion of cause death? |
| Comp | | | | | | | | 106Y | es 2 No | | Lyes 2□ No |
| BeC | 25. Was case referred to medic | al | | | | 26 Place | of Death (C | check only or | | , | |
| 0 | examiner? 1 X Yes 2 No | Hospital: 1 🗆 Inc | patient 2 El | R/Outpalier | nt 3 DOA | Other: | | | | ner (Specif | y) Scene |
| funeral di | 27. Manner of Death | 28a. Date of | | 8b. Time o | | njury af Work? | - | | ow injury occur | | ,, 000110 |
| catio | E M MODICOTIL | figation 131 | 00 3 | 3:23 | PM | 1 Yes 2 | Vo Va | DESTRIA | N STVUCK | RY | 4 TRUCK |
| ti e | 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | treet and Num. n, Steta) No/1 | ber or Rure | Al Routa Number, |
| Certification: | | | | STREE | ET | | | | THILL, I | | לשויואל |
| edical | | ing Physician: To the bear in Examiner: On the base and manner | is of examinatio | | | | | due to the d | ause(s) and m | anner as s | |
| completely filled in by the Medical Certification | 29b. Signature and title of cartif | | | | 29c. Lic | ense number | | 1 | 29d. Date signe | ed (Month, | Dey, Year) |
| |) () | MI. 1 | 1 | | | O.C.M.E | | | Febr | ימפור | 1, 2000 |
| | 30. Name and address of perso | n who completed cause | of death (Item 2 | 3a) (Type. | | 0.0.11.11 | • | | 1 CDI | . aur y | 1, 2000 |
| 0 | JACK M. | Tirus m. |) | | | Street | , Bali | timore | , Marvl | and 2 | 21201 |
| State | 31. Date filed (Month, Dey, Yea | r) 32. Reg | istrar's Signatu | | | | | | | | |
| Registrar | FEB 3 | 2000 | Seneva | 1 | 1 6 | 2 1 | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 4:00 p.m. Rothwell 29, 2000 Lucille January 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Lexington Park If Under 1 Year | If Under 24 Hrs. | 8. Dete of 1 St. Mary's Bayside Care Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Days Min 1□M 20 F Yrs. 218-34-5061 Oct. 17,1917 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 █ No Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Windsor Drive 20653 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Martin Monroe Victoria Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Perry A. Rothwell / Son P.O. Box 307, Lexington Park, Maryland 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2-3-00 Leonardtown, MD 21. Signatule of Fundral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Du Ald, Brinsfi Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Refure Due to (or es a consequence of) Due to (or as e consequenca of) 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Physician /Medical Examiner

certificate be exec

Division of Vital Records,

or Attending

Hospital

To the within 2

Physician

/Medical

Examiner

10e. State

12

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Directo

Funeral

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Completed

Be

with the Maryland

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filed within 72 hours after

Hygiena.

other traumatic event.

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 is marked oth any lollury or other traumatic event pine.

altimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed

shysician and the bunal-trans physician 88 980 page 2 s certificete has After this luneral 24 hours after death. Funeral Director: A filled in by

500

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. Were autopsy findings available prior to completion of cause of death? 2018 2 NO 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Be examiner? Other: 4 Tursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, efc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and pranner stated. 29e. Certifier Medical (Check only

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and Storess of person who come oled charge of death (Item 23a) (Type, Print) 23415 Three Notch Road, California, MD 20619 M.D. R. Boyd, James FEB 0 32. Registrar's Signature

State Registrar

29b. Signature and title of certif

03

2000

DHMH 16 Rev 6/95

ES 0 8 2000 June 15 days at

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 2 4 5 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death

7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) August 15, 1919

Physician /Medical Examiner

Director

Funeral

P

Completed

Woodrow Wilson 4a Facility Name (If not institution, give street and number) Rice

10f. Zip Code

20656

Month February 10, 2000

U.S.A.

St. Mary's Hospital

4b. City, Town, or Location of Death Leonardtown

4c. County of Death St. Marv's

7:50 AM

9. Birthplace (State or Foraign

Funeral Director

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylen Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or flams 23s or 28s-1 show any futury or other traumatic event, the Medical Examples that the notified and page.

Physician

/Medical

Examiner

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certificate

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After

death.

within 24 hours after death.
To the Funeral Director: Af

director.

Examiner

Physician/Medical

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Completed

Be

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Certification:

10a State Maryland 10e. Street and Number

Usual Residence of Decedent 10b. County St. Mary's 40380 Parsons Mill Road

10c. City, Town or Location Loveville

10d. Inside City Limits 1 Yes & No 10g. Citizen of What Country?

Mary Tand

11. Marital Status

5. Social Security Number

217-36-7987

1 Nevar Married X Married 3 ☐ Widowed 4 ☐ Divorced

Sex TOM 20 F

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ऄ☐ No tf Yes, Give Yaar or Dates:

College (1-4or 5+)

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes AN No Specify:

14. Raca - American Indian. Black, Whita, atc. Specify:

White

15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use ratired) Maintenance Worker

16b, Kind of Business/Industry Board of Education

7th 17. Father's Nama (First, Middla, Last)

Daniel Webster Ryce

18 Mother's Name (First, Middle, Maiden Sumama) Maude Rosalee Wenk

19a. tnformant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) P.O. Box 91, Loveville, Maryland 20656

Alice Imogene Rice/ spouse

20b. Place of Disposition (Name of cematery, crematory or other place)

20c. Location - City or Town, Stata 2/12/2000 Morganza, Maryland

20a. Method of Disposition

NO Burial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify)

St. Joseph's Cemetery

22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.

21. Signature of Funeral Service Ligas

arderen 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

UROSEPS15

MRINARY TAACT IN BECTLOW

Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE CEREBROVASCULAR DISEASE

23b. Did tobacco usa contributs to the cause of death? 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera autopsy findings available prior to completion of causa of death?

BRONCHIECTASIS

5 Pending

invastigation

6 Could not be datarmined

FEB 1 1 2000

1□ Yes 2 No 26. Place of Death (Check only one)

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death

Hospital: 1 | Hapatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No

29a. Cartifiar

1 Natural

2 Accident

3 ☐ Suicide

4 Homicida

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certified

29c. License number 40593 29d, Data signad (Month, Day, Year) 00

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) Hollywood, Maryland 20636

A.K. Shah, MD 31. Date filed (Month, Day, Year)

32. Ragistrar's Signature parks Deneva

State Registrar

DHMH 16 Rev 6/95

Division of Vital or Attending Physician:

The law requires that the death certificate be executed Records, P.O. Box 68760,

TERLITOR Jones & france

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Das **Physician** February 06, 2000 James Robert Reed 2:12PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center La Plata Charles If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** Days 1■M 2□ F Months Hours 216-22-4783 Director 85 Jan.10, 1915 Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits show must be notified at 1 Yes 2 No Director 280-7 Charles Maryland LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 hams 23a One Magnolia Drive 20646 Funeral United States 14. Race - American Indian, Bleck, Whita, atc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Detas1 942-43 filed within 72 hours after 1 ☐ Never Married 2 ☐ Married "natural", or Maryland 21215-0020 1 Yas 2 No Specify: à 3 Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Service Fireman US Government Department of Health and Mental High Important: If Item 27 is marked other any Injury or other tree. 17. Father's Nama (First Middle Last) 18 Mother's Nama (First Middle Maiden Sumama) Be Robert Reed Emma Smallwood 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Price / Daughter 49378 Old Barnes Way, Ridge, Maryland 20680 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ■ Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2-12-00 Leonardtown, MD 21. Signifilant of Funeral Service Moons 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. Brindielo, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Inlarval Batween Onset and Death Physician /Medical Immediate Cause (Final Aspiratui disease or condition resulting in death) Examiner Examiner lmona attending physician and for use as the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the bed signed by t 1 Yes 2 No 3 Probably 4 Nonknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed Deen page 2 2K No certificata 1 ☐ Yes 1 Yes 2 No al or Attending Physician: The after death.

If Director: After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitet: 1 Agpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier ECritifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Box 68760. P.O. Records, Division of Vitai n 24 hou. Puneral Dir Hospital To the Hast within 24 ha To the Fund completely t

Baltimore,

N

29c. License number

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s)

D-45737

29d. Data signed (Month, Day, Year) 7/00 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nirmaladevi Gurusamy, MD 6 Post Office Road, Suite 103, Waldorf, Maryland 20602

State Registrar

31. Data filed (Month, Day, Year) FEB 1 0 2000

29b. Signature and titla of certifier

32. Begistrer's Signatura

and manner steted.

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Some & Speed

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Suzanne Mae Runge January 2000 10.05 AM /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M MOXF Yrs. Director 53 Dec. 3, 1946 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 3 ☐ No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Norma 23a 824 D. Windstream Way 21040 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, o filed within 72 hours efter de l'Hygiene. Other than "natural", or item Black, White, etc. 1 Never Married 20 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) Elementery/Secondery (0-12) Educational Manfacturer Software Analyst 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Nem 27 Is marked oth Elmer George Schlutz Louise (nmn) Perthel 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robyn Wyatt/ Friend 40 Crows Foot Dr., North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stets 1 □ Burai 2 ☑ Cremation 3 □ 4 □ Douation 5 □ Other (S.) 3 Regrioval from State Department of Important: If any injury or pace. 5 Hilltop Service Corp. 2-3-00 Towson, Maryland 21. Signature of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 prication thet caused the death. Do not enter the mode of dying, such as Cardiac or respiratory arrest, Approximate a ADENOCARCINOMA of PLAURA + LUNG 8 MONTHS **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): physician street Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): usa 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 12 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Affer Division Attending 1 ANetural 5 Panding investigation 1 Yes 2 No thin 24 hours after death.

the Funeral Director: All mpletely littled in by the fu r death. 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 4 Homicide 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contine 331775

State Registrar 31. Data filed (Month, Dey, Year)

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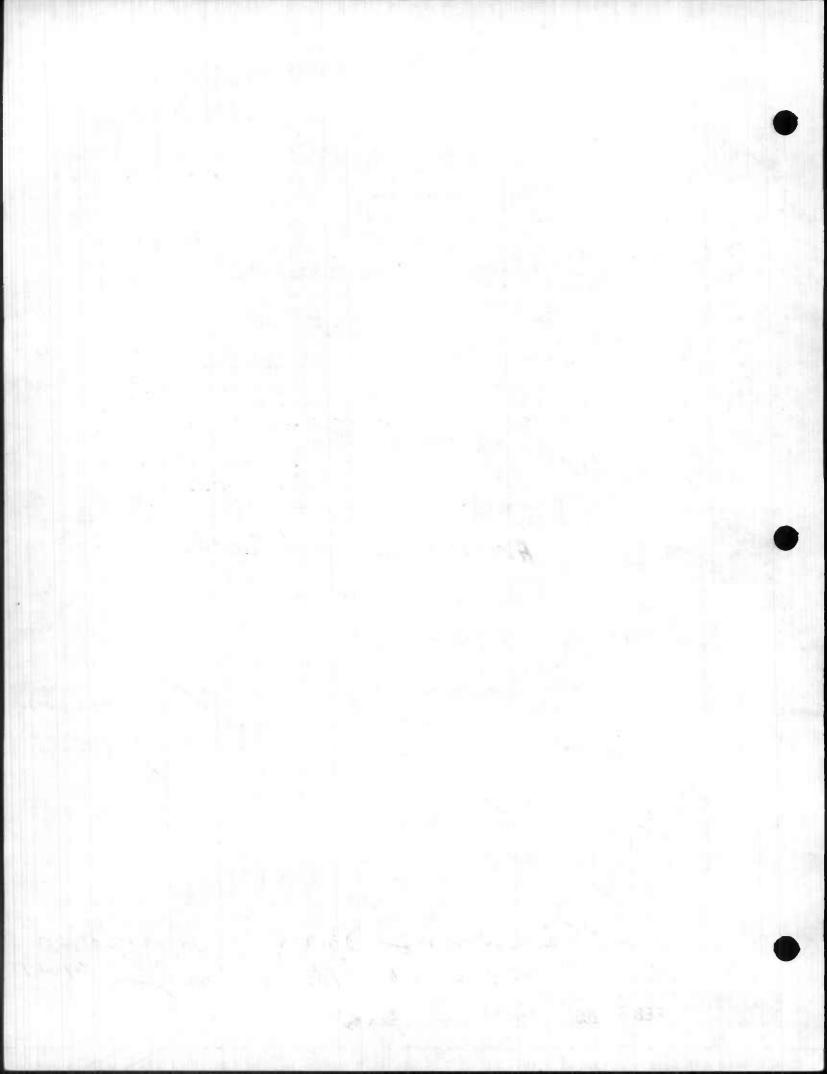
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who completed cause of Iteath (Item 23a) (Type Print)

32. Registrar's Signatura

2112 MELAIR



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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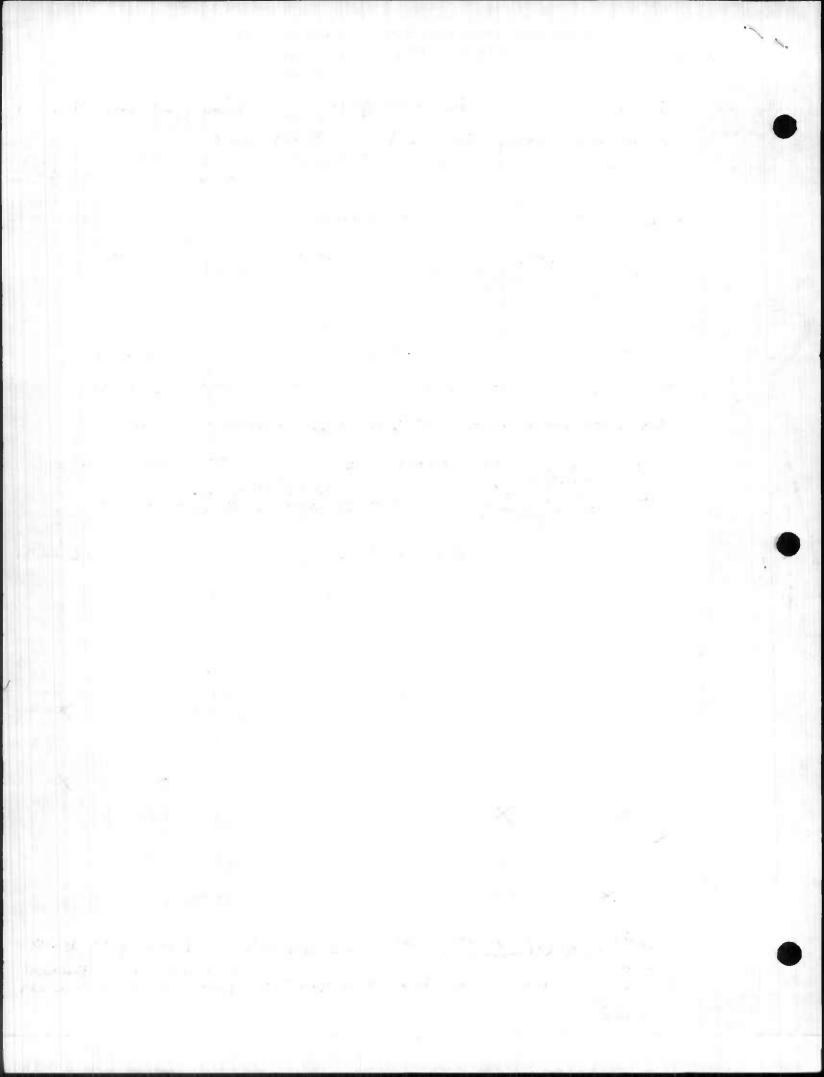
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 218106238 State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#1 HCHD 1/27/2000 Certificate of Death 1. Decedent's Nama (First, Middle, Last) WILLIAM ARNOLD ROSENBERGER 2. Data of Deeth **Physician** osenberger Month 5:30 AM 2500 January /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Hospital Baltimore If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months 2/8 /0 6238 Usuai Rasidanca of Decedant M 2□ F Director 80 Nov. 8, 1919 Maryland the Marylend or 28a-f show a nettfled at 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits ty Yas 2□No Director Penna. Vork Stewartstown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Items 23a 22 South Main Street 17363 USA Funeral Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American indian, Biack, White, atc. filed within 72 hours efter 1 Navar Marriad & Married 1 ☐ Yas 2√2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yas 20 No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Induatry nd Mental Hygiene. marked other than Eiementery/Secondery (0-12) Coilega (1-4or 5+) 12 Engineer Communication traumatic event, 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maldan Surnama) Pages 1 and 2 should be 1 nent of Health and Mental I Forund J. Rosenberger Laura (mmn) Magsammen 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 60 Health a Esther J. Rosenberger - Wife 22 S. Main St., Stewartstown, PA item 27 17363 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any Injury or c 1 Buriai 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other Specify) Spesutia Cemetery 1/27/00 Perryman, Maryland of Funaral Survio 22. Nama and Addrass of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. P. 111 Enter the difference or complete the first au sed the **Physician** /Medicai Circhosis Immediata Causa (Finel > 6 Months diseese or condition rasulting in deeth) Examiner Due to (or as a consequence of) Examiner thet the death certificete be executed Sequentially ilst conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that initiated avants raaulting in daath) Last Dua to (or as a consequance of): P.O. Box 68760. Physician/Medical the Dua to (or as a consequence of): 98 Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably A Unknown Records. should be d þ 24a. Was an autopsy performad? 24b. Wara autopsy findings available prior to completion of cause of death? Completed page 2 1 ☐ Yas 25 No certificate Vital Physician: director. Be 25. Was casa rafarred to medical 26. Placa of Deeth (Check only ona) axaminer? Hospital: 1 Inpatiant 2 EFVOutpatient 3 DOA 2 No Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) To 1 Yas of this in by the funeral 27. Mannar of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 5 ☐ Panding invastigation Natural 2 Accident death. 1 Yas 2 No efter death 3 ☐ Suicida 6 Could not be 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) Placa of injury - At home, farm, streat, factory, offica building, atc. (Specify) 4 Homicide 6 within 24 hours To the Funeral (Hospital Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and piace, and dua to the cause(s) and mannar as stated.

| Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and mannar stated. completely å E 29b. Signatura and titia of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) Physician D0054303 30. Name and address of person who complated causa of death (Item 23e) (Type, Print) 5601 Lock Rover Rayound 0 Good Samaritan Hospital Z.A. ELDADAH, MD Baltmore, Maryland 21239 31. Data filed (Month, Day, Year)

JAN 2 7 2000 2. Ragistrar's Signatura State Registrar

DHMH 16 Rev 6/95



00-0496-25 crn Johanna Frances Ryan

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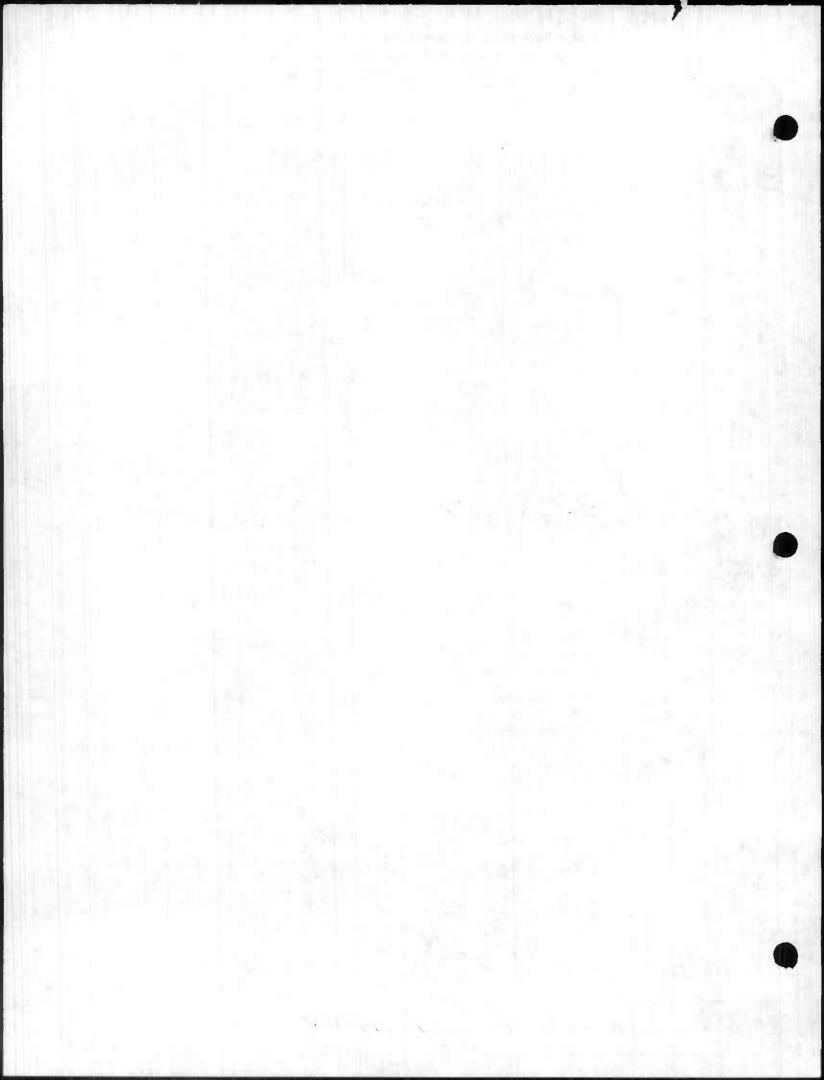
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| er | 4e Facility Name (If not institution | | oer) | | | 4b. City, Town, | or Location of Dea | ith 4c. Cour | ty of Death | |
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| - | 5. Social Security Number 220-38-5437 Usual Residence of Decedent | 6. Sax 7. | Age (In yrs. last | Yrs. | Months Day | | Ain. (Month, L | inth Day, Year) 1/39 | 9. Birthp Cour Mary | pleca (State or Foreign ntry) land |
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| | Herbert A. | Lux | | | | Mar | y C. Qu | inn | | |
| | 19e. Informent's Neme/Reletion | ship (Type, Print) | 1 | 19b. Melling | g Address (Street | et end Number o | r Rural Route Num | ber, City or Tow | m, State, Zip | Code) |
| | Steven J. Uk | ura- son | 4 | 616 | Clermo | nt Mil | 1 Rd., F | ylesvi | 11e, | MD 2113: |
| | 20e. Method of Disposition 1 Spariel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (5) | | ate ceme | etery, crem | ition (Name of atory or other pi | | 1/28/0 | 20c. Location | | own, Stata |
| | 21. Signeture of Funerel Service | Licensee | lida | 22. | Neme end Add | ress of Fecility | c., De1 | | | |
| | 23a. Part1. Enter the disaase, of the disaase, of the disaase, of the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the disaase, the | | | | r tha moda of d | ying, such es car | diec or respiratory | arrest, | 1 | Approximate Intervel Between Onset and Daeth |
| | Immediate Causa (Final disasse or condition rasulting in deeth) | Cardi | ac Arryt | thmia | | | | | S | Sudden |
| | | 17 | Due to (or es | | | | 2. | | 1 | |
| Cxamine | | hyper b. Hyper | | | | cotic Ca | rdiovasc | ular Di | sease | Years |
| 2 | Sequentially list conditions, if any, leading to immediate | | Due to (or es | a consequ | Jenca of): | | | | = 1 | |
| Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last | c | Due to (or es | a consequ | ence of): | | | | 1 | System System |
| 5 | Doed It Other plantificant conditi | | the ferral and an arrivation | _ != *b= | ded de cours | has is Oad I | 225 DI | d tobassa usa | | o the cause of death |
| ay mysicians | Pert II. Other significant conditi | ona contributing to dea | outing to death but not resulting in the underlying cause given in Part I. | | | | | | | bably 4 \Unknow |
| | | | | | | | 24e. Wa | is an autopsy tormed? | av | fere autopsy findings railable prior to empletion of cause |
| 200 | | | | | | | | pection | of | death? |
| | 25. Was case refarred to medical | 1 | | | | 26. Plece of | Deeth (Check only | y one) | | |
| | examiner? 1X Yes 2 No | Hospital: | atiant 2 ER | /Outpatient | 3 DOA | Wher: | ng Home 5 XRe | | ther (Speci | (y) |
| | 27. Manner of Deeth 1. Neturel 5 Pandi 2 Accident Invest | 28e. Dete of (Month, gation | Injury 28 Dey Year) | b. Time of Injury | 28c. In W | ury at lork? □ Yas 2 □ No | 28d. Describ | e how injury occ | eurred | |
| | 3 Suicide 6 Could 4 Homlcide determ | nined 200. Place 0 | f Injury - At home , etc. (Specify) | , ferm, stre | et, fectory, offic | | | | | |
| - Ballon | 29a. Certifier 1 Certifyin (Check only 2 Standical one) | ng Physician. To the be Estiminer: On the bas and manne | is of examinetion | dge, deeth end/or inv | occurred at the estigation, in my | time, date and p | lece, and due to the | e ceuse(s) end e, date and plac | menner as s e, and due t | itated. o the cause(s) |
| | 296. Signature appears of certific | Suc | ale | Qu | | C.M.E. | | 29d. Date sig Januar | | |
| 1 | 30. Neme and address of person | who completed cause | of death (Item 23 | | | | - | | | 01055 |
| | John E. Smiale | | Chief ME | w | II Penn | Street, | Baltimo | re, Mary | Land | 21201 |
| 9 | 31. Data filed (Month, Day, Year, | 32. Rec | jistrer's Signature | 1 | | | | | | |

State

Registrar

JAN 28 2000

Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 2 Dev MARY REDWINE CLOONAN 4 2000 1530 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER Birthplece (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Min Deys 1 M 2 F Months Hours 018-03-9363 Usual Residence of Decedent 10e State 10c. City, Town or Location 10h County 10d. Inside City Limits MD. WORCESTER OCEAN CITY 1 ☐ Yes PONO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10213 GOLF COURSE RD. 21842 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes SECNO If Yes, Give Year or Dates: 14. Rece - American Indian. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 □ Never Merried 2 □ Merried 1□ Yes 2KNo Specify WHITE Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) O'DONNELL MARTIN CLOONAN MARGARET 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) WILLIAM K. REDWINE JR. 6618 NAHOL DR. FREDERICK, Mp. 21702 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State MD. VETERANS CEMETERY HURLOCK, MD. 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. 21811 of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thank feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth INTRAABBOOMINAL SBPSIS Due to (or as a consequence of): RESPIRATORY FAILURE Immediate Cause (Final diseese or condition resulting in death) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown 24e. Was an autopsy performed?

Physician /Medical Examiner

ician and bunal-trans

the

usa as I

Aftar this cartificata has funeral director, paga 2.

or Attending Physician:

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At

þ

Completed

Be

Certification: To

Medical

29e. Certifier

certificate be axec physician

018-03-9363

Physician

/Medical

Examiner

Director

by Funeral

Completed

Funeral

Director

mportant: If item 27 is marked other than "natural", or items 23a or 28a4 show any injury or other treumatic event, the Madical Examiner must be northed at

death

Pages 1 and 2 should be filed within 72 hours aftar

Departmant of Haalth and Mental Hygiena. Important: If item 27 le merked other than "naturaf",

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medical

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 00

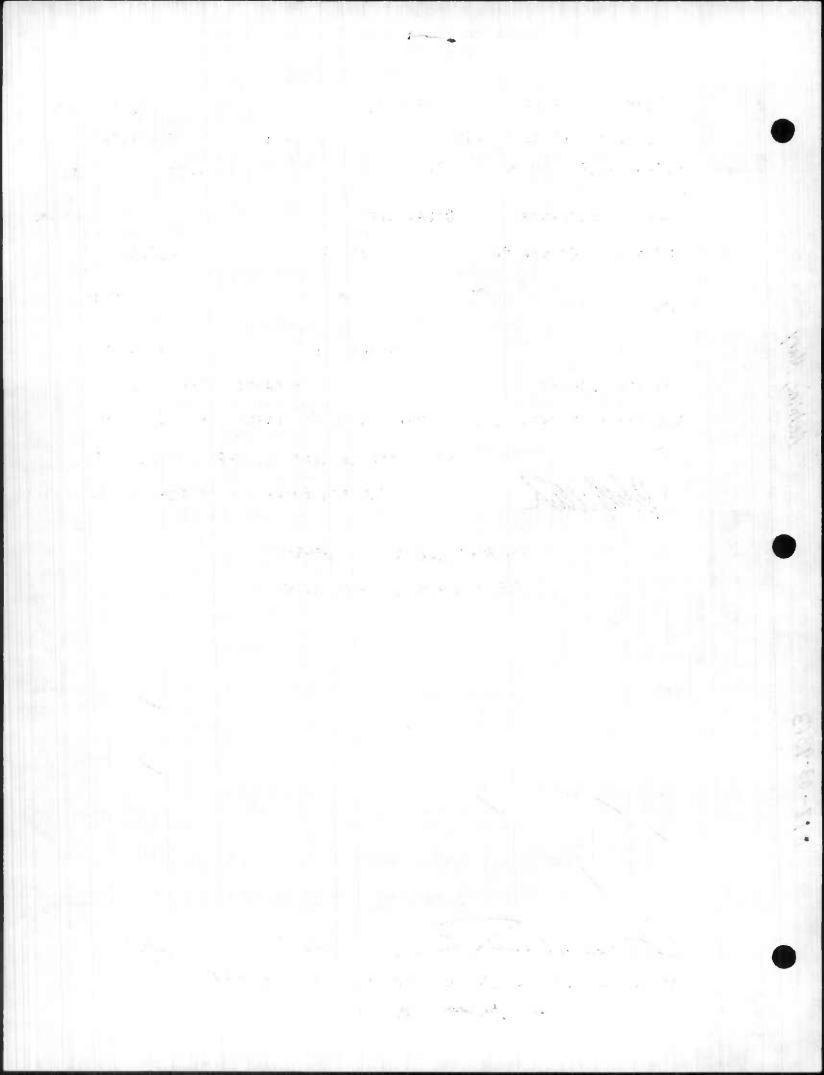
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Healthway Berlin Drive

State Registrar

completaly

31. Dete filed (Month, Day, Year) FEB 07

32. Begistrer's Signeture



Memorial Hospital Easton

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Robinson

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 22, Jan. 2035

Easton

4b. City, Town, or Location of Death

4c. County of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

455

1 Yes 2 No

1 ☐ Yes 2 No

Talbot

| | 1. Decedent's Name (First, Middle, Last) |
|-----------|---------------------------------------------------------------|
| Physician | |
| /Medical | William J. |
| Examiner | 4e Facility Name (If not institution, give street and number) |
| LAMINICI | Memorial Hospital East |

Funeral Director

must be notified at the Maryta Items 23a natural, or

Baltimore, Maryland 21215-0020 Pages 1 and 2 should be nent of Health and Mental Department of Health of Important: If Item 27 is any injury or other tra

William Robinson

Physician /Medical Examiner

physician and s the burial-transit The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. or Attending Physician: funeral After 24 hours after death.

Funeral Director: A

If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Deys 10 M 2 F Hours 70 Nov. 1,1929 213-24-2294 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location Director Maryland Queen Annes Grasonville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 112 Forest 21638 USA Road Funeral 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: 1952 -1954 **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Janitor Fisherman's Inn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be William Robinson Ruth Askins 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 310 N. fourth Street, Denton, Maryland 21629 Terry Johnson , Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 1/31/2000 Beulah, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Funeral Bennie Smith Home P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on eech line. Immediate Cause (Finel disease or condition resulting in death) stage ein Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Physician/Medical Due to (or as e consequence of): Part II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown panicreatic þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? cancel 1 Yas 2 No 25. Was case reterred to medicel exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 PNetural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signefure end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23

completely

State

Registrar

To the F within 2

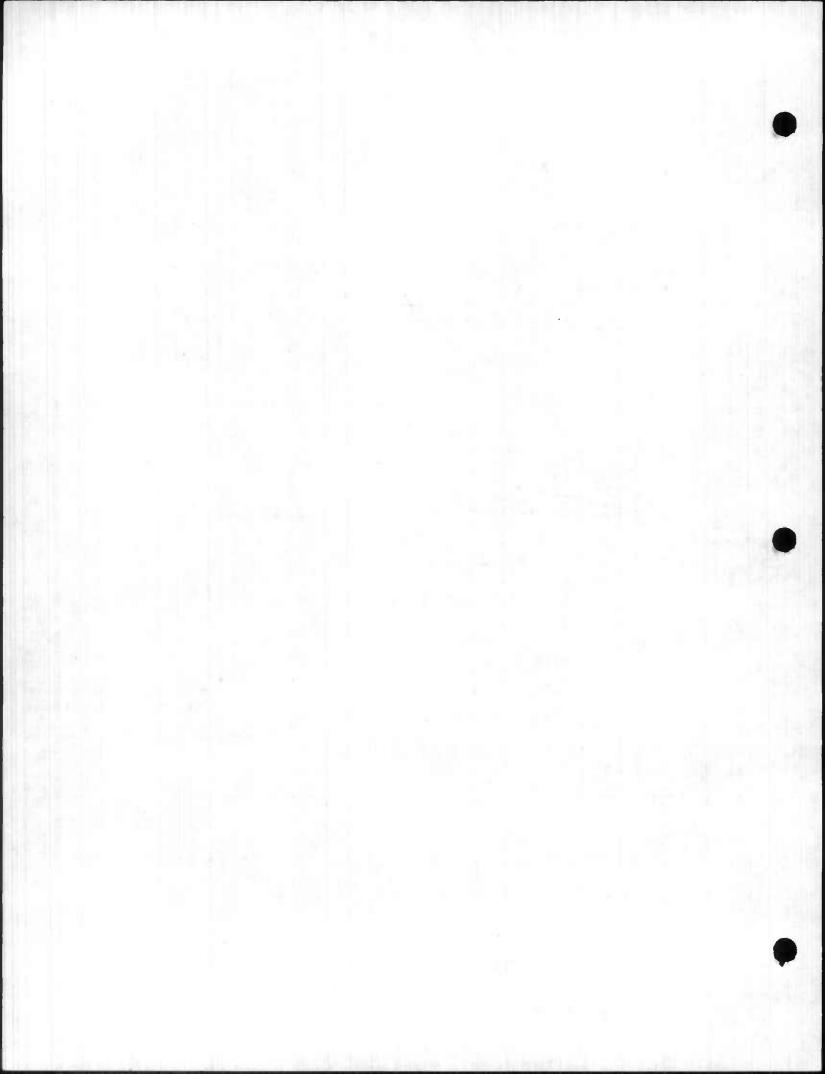
Dr. Peter Whiteshell, 508 Idlewild Ave., Easton, Maryland 21601

32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

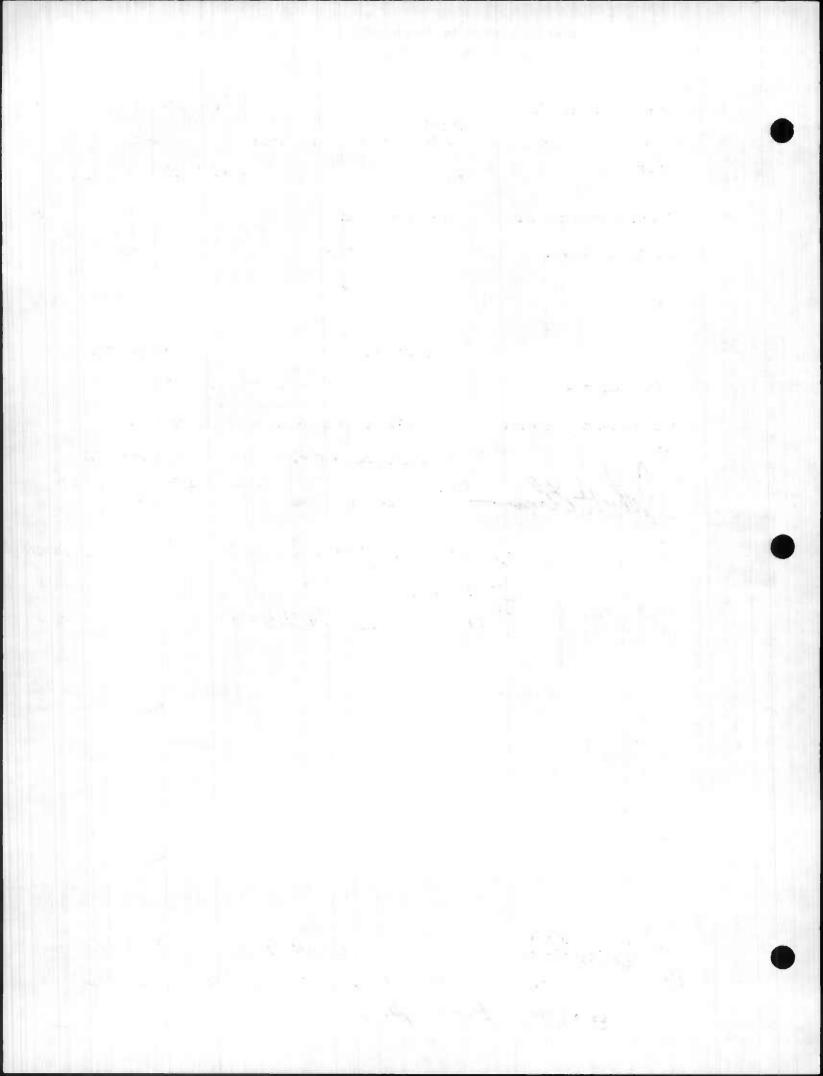
JAN 3 1 2000

31. Date filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene

| | | | | | State of W | aiyiaii | | tificate of | Death | | Reg. No. | 0 | 5253 | | |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------|----------------------------|---------------------|-----------------------------------------|-------------------------------------------------------|------------------------------------------|------------------------------|---------------------------|-------------------------------------------------------------------|--|--|
| | Physicia | | 1. Decedent's Neme (| | Last) | | | | | 2. Date of Dea Month | Day | Year | 3. Time th | | |
| | /Medic | al | FRANCES (| | VLINGS | | | | | Februa | ry 6 | 2000 | 1: 5 M | | |
| | • Examin | er | | | give street and number) | CITAL | | | 4b. City, Town, or L | | | | | | |
| | | | County Nui 5. Social Security Nun | | and Rehabil | | Ion Cer | if Under 1 Year | La Plata | | Char. | | alana (Otata as Fassian | | |
| | Funeral Director | | 227-36-003 | 32 | 1□ M 2/□ F | 82 | Yrs. | Months Deys | | 8. Dete of Birt (Month, De Oct. 3. | 1917 | Cour | plece (Stete or Foreign ntry) jinia | | |
| | and ** | - | Usual Residence of D 10e. State 1 | lob. County | | 10c. City | y, Town or Lo | cation | | | | 1 | 10d. fnside City Limits | | |
| | Ba-f sho | ctor | Virginia V | Westmo | reland | Col | lonial | Beach | | | | | 1 ☐ Yes 2 🖾 No | | |
| | death with the Maryland me 23a or 28a-f show man be notified at | Funeral Director | 400 Monroe | | et | | | 10f. Zip Code 22443 | | | | USA ce - American Indian, | | | |
| 020 | permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-1 shown any injury or other treumstic event, the Marical Experience must be notified at ONEs. | Be Completed by Fune | 11. Marital Status 1 ☐ Never Merried 3 ☒ Widowed 4 | | 12. Was Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give Yeer or Detes: | | 1 | Nes Decedent of I t Yes, specify Cub | Hispanic Origin? (S en, Mexican, Puert Specify: | pecify Yes or No o Rican, etc.) | | ck, White, y: White | etc. | | |
| Baltimore, Maryland 21215-0020 | ithin 72 ha na. nan "natu | | (Specify Elementary/Second | | Education grade completed) College (1-4or | 5+) | | | pation during most of wor ed) | king | 16b. Kind of B | | | | |
| 7 | hor th | | 12 17. Fether's Neme (Fi | inat Adiodollo I a | | | Record | aer | 10 Mathara Nam | o /First Middle | US Government | | | | |
| and | od of | Be | Judson Je | | ist/ | | | | | staples | | 10) | | | |
| Z | should ind Men marke umatic | 2 | 19e. Informent's Nem | | D (Type, Print) | | 19b. Meilin | no Address (Street | t end Number or Ru | | | Stete. Zic | Code) | | |
| Z | end 2 sho saith and n 27 ie ma | | Myra A. S | | | | | | d Drive W | | | | | | |
| re, | of Health of Health item 27 | - | 20a. Method of Dispos | sition | | 20b. P | | sition (Neme of netory or other ple | | Dete | 20c. Location | | own, State | | |
| E | Pages nent of I int: If its | | ALX Burial 2 0 4 0 Dometion 5 | | Removel from Stete | | | n Nat'l | | 2/14/00 | Arling | ton, | VA | | |
| Balt | Departme Departme Importan any injur | | M00173 22. Name end Address of Facility Nash and Slaw Funeral Home 149 3rd Street Colonial Beach, VA 3a. Pard. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, speck, or heart feiture. List only one cause on each line. Approximate Interval Between | | | | | | | | | | | | |
| | Physician | | 23a. Pard. Enter the stock, or heart t | diséase, or or feilure. List or | omplications thet caused aly one cause on each li | d the deeth | | er the mode of dyi | ing, such as cardiac | or respiretory e | | | Approximate Interval Between Onset and Death | | |
| 9. | /Medical Examiner | | Immediate Cause (Fir disease or condition resulting In deeth) | nai | . Dehi | Idra | utron | Ma | lnur | hon | | | 6 months | | |
| | Srit and | liner | | | Depr | Due to (o | r as a conseq | uence ot): | | | | | years . | | |
| 60, | ifficate be axecuted g physician end es the burial-transit | ai Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events) County (Disease or Injury that Initiated events) | | | | | | | | | | years. | | |
| x 68760, | certificate iding phys | Medical | | | | | | | | | | | | | |
| Box | after of for u | clar | Death Other death | | and the standards have | | data a la aba con | - 4- 4 (| in Death | oah Did | lahasas usa sa | and of the state of | to the cause of death? | | |
| P.O. | that tha ced by the detached | Phys | Pett II. Other eignines | ant condition | contributing to death b | ut not rest | Jitting III (rie ur | idenying cause gi | ven in Petti. | | Yee 2 1540 | | bably 4 Unknown | | |
| Division of Vital Records, | The law requires that tha daath certif ate has been signed by the attending page 2 should be delached for use e. | Completed by | | | | | | | | | en eutopsy med? | av cc | fere autopsy findings vallable prior to ompletion of cause deeth? | | |
| ď | The lay ste has page 2 | E | | | | | | | | 10 | Yes 2X No | 11 | ☐ Yes 2☐ No | | |
| ita | nysicien: The la his certificate has I director, page 2 | | 25. Was case reterred exeminer? | d to medical | | | | | 26. Place of Dee | th (Check only o | ne) | | | | |
| > > | Physic this ce ral dire | 2 | 1 ☐ Yes 2000 | 0 | Hospitel: 1 Inpatie | ent 2 🗆 | ER/Outpation | I 3LI DOA | | ome 5 Resid | | | fy) | | |
| ion | The Tag | ation: | 27. Manner of Death 14. Naturel 2 Accident | 5 Pending investiga | 28a. Dete of Inju (Month, De | y Year) | 28b. Time of injury | Wo | nryet ork?]Yes 2 □ No | 28d. Describe | now injury occur | rred | | | |
| Divis | after da Directo d in by th | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could no determin | | ury - At ho c. (Specif) | ome, term, stre | eet, tactory, offica | | 28t. Location (: City or Tox | Street end Num vn, Stete) | ber or Run | al Route Number, | | |
| | To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral | Medical C | | | Phyeician: To the best caminer: On the basis o end menner st | t examinet | | | | | | | | | |
| | omple | | | | | | | | | | 29d. Date signe | | | | |
| | ->-0 | | 1 / 5 | 1/1/1/ | Ma | | | D4 | 16419 | | 2/ | 7/0 | 0 | | |
| | | | 30 Neme end address | s of person with A. Le | no completed cause of a | deeth (Item | 23a) (Type, | Print) Charlo | 16419 s St Lo | Plata | MD 2 | 2064 | 16 | | |
| | Sta | | 31. Dete tiled (Month, | Dey, Year) | 32. Registr | | ture 4 | Low | 12 | | | | | | |
| | Registra | ar | 171 | ED 18 | 2000 | The same | 1 | - postores | Pla gir | | | | | | |



Rileg

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | | Cer | tificate | of | Death | | Re | g. No. | | | |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------|----------------------------------|----------------|-----------------------------------------------|-----------------------------------|-----------------------|--------------------------------|------------------------------------|------------------|----------------------------------------|
| | Bloods | | 1. Decedent's Nama (First, Middle, Last) | | | | | | 2. Date Mo | e of Death | 1 | Year | 3. Tin | na of Death |
| | Physic /Medi | | Carlotta Lee Rile | y | | | | | 1 | nua | ry 24 | | 0 1 | 5:05 am |
| 1 | Examil | | 4a. Facility Name (If not institution, give street | and number) | | | - 1 | 4b. City, Town | , or Location o | | 4c. County | of Death | _ | |
| | | | Futurecare - Chesape | ake | | | | Arnold | | | Anne A | runde | ∋T | |
| | Funeral Director | | 5. Social Security Number 220–16–9168 Usual Residence of Decedant | 7. Age (In yrs. I | | If Under 1 \ | Year Days | if Under 24 Hours | Min. 8. Date (Mo | of Birth oth, Dey, | Year) 1921 | 9. Birthpi Coun Mary | try) | ete or Foreign |
| | and and | | 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | | | 11 | 0d. Insk | de City Limits |
| | Many 4 aho | P | MD Anne Arund | lel Anı | napoli | S | | | | | | | | Yas 2 □ No |
| | the 128s | Director | 10e. Street and Number | | - | 10f. Zip Co | ode | | | 10 | g. Citizen of \ | What Coun | try? | |
| | 3a o | | 701 Glenwood Road, | Apt. 409 | | 214 | 01 | | | | USA | | | |
| 21215-0020 | should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f ahow umatic avant, the Medical Evantine must be notified at | by Funeral | 11. Marital Status 12. W A 1 Nevar Married 2 Married 1 If | as Decedent Ever In U, med Forces? ☐ Yes 2 12 No Yes, Give ear or Dates: | Н | Vas Decedan Yes, specify | Cub | Ilspanic Origin an, Mexican, P Specify: | n? (Spacify Ye Puarto Rican, a | s or No- | | e - Amaric ck, Whita, e v: W | | |
| 2-0 | 72 ho | Completed | 15. Decedent's Education | ninted) | 16a. Deced | ent's Usual C |)ccup | ation | f warding | 1 | 6b. Kind of B | usiness/inc | Justry | |
| 2 | ithin 7 | nple | (Specify only highast grada com Elementary/Secondary (0-12) C | plated) bliege (1-4or 5+) | life. D | Telle | retire | during most of d) | i working | 20 | | | | |
| 2 | od w | S | 7 | | Dalik | тетте | T. | | | | Bankin | | | |
| Maryland | 2 should be filed within and Mental Hygiene. Is marked other than reumetic avent, tre Mental tre Mental tre Mental tre Mental tre Mental tre Mental tre Mental tre Mental tre Mental tre Mental tre Mental tre Mental tre Men | Be | 17. Father's Name (First, Middle, Last) | | | | | | Name (First, | | | | | |
| <u>~</u> | i Mer Marka Marka | 1º | (unknown) Riley | | | | | | rence G | | | - | | |
| <u>a</u> | C1 00 - | | 19a. Informant'a Name/Relationship (Type, P | | | | | end Number o | | | - | | | |
| | Heelth Heelth Sem 27 | | Kenneth H. Fields, | | I Z8 I | | | Road, | Date | - 0 | Oc. Location - | 21787 | | to |
| آور | Peges nent of i | | 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramov | al from Stata | emetery, cren | netory or otha | r pla | ce) | Jan | 29 | | | | 10 |
| altimore, | it. Pertant | | 4 Donation 5 Other (Specify) | Me | etro Cr | | - | 4 Facility | 2000 | | | more, MD rk Funeral Home | | |
| Ba | permit. Pege Department of Important: If any injury or ance. | | 21. Signature of Funeral Service Licensee | | Ba | rranco | S & | Sons, | P.A. S | Sever | na Par | k Fur | nera | 1 Home |
| | Physician /Medical Examiner |)r | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car immediata Cause (Final disease or condition resulting in death) | Pueu i | , | a | of dyir | ng, such as ca | rdiac or raspir | atory arre | St, | | | dimata i Between and Death |
| 30x 68/60, | leeth certificate be executed ettending physician and I for use es the burial-transit | an/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| . B | 0 0 | Physician | Part II. Other significant conditions contribut | ng to death but not resu | uiting in the un | derlying caus | sa giv | an in Part I. | 23 | b. Did tol | pacco use co | ntribute to | the ca | use of death? |
| s, P.0 | es that the de- igned by the e be detached f | by Phy | Rd Cerebovor | Brear. | - | | | | _ | 1 🗆 Ye | 2 No | 3 Prob | ably | 4 Unknown |
| ecords, | been s | Completed | old Cerelio voro | enter A | leved | ent | | | 24 | a. Was ar perform | | ava | ailabie p | psy findings prior to n of cause |
| <u> </u> | The law ate has page 2 | Con | | | | | | | | 1 ☐ Ye | s 200 No | 1[| Yas | 2□ No |
| Vital | certificate | Be | 25. Was case referred to medical examiner? | | | | Lati | | Death (Chec | k only one |) | | | |
| 0 | Physician: this certific ral director, | 6 | 1 ☐ Yes 2 ☐ No Hospit | 1 ☐ inpatiant 2 ☐ I | ER/Outpatien | | Oth | 4 Nursi | ing Homa 5[| | | | 1) | |
| | 0 0 0 | on: | 1 Natural 5 ☐ Pending | a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. | Injur | | | scribe ho | w injury occur | red | | |
| S | Attending or death. actor: After by the fune | cat | 2 Accident investigation 3 Suicide 6 Could not be | Yes 2 No | | -11 (0) | | | 15. 1 | A1 | | | | |
| Division | tal or Al rs after al Dirac led in by | Certification: | 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) | | | | | | | | | | | |
| | To the Hospital or Attendin within 24 hours after death. To the Funeral Diractor: Att completely filled in by the fur | edical | 29a. Certifiar (Check only one) 1 Certifying Physician 2 Medical Examiner: Care a | To the best of my known the basis of examinating manner stated. | vledge, death ion and/or inv | occurred at to estigation, in | ha tir my o | na, data and p ppinion, death o | piace, and dua occurred at the | to tha ca time, da | usa(s) and ma te and piace, | innar as st and dua to | ated. tha cau | use(s) |
| | To the within To the comp | M | 29b. Signature and titla of certifiar Culywarms A | therding | Doct | | | e number | 84 | | d. Date signe | | | |
| | | | 30. Name and address of parson who compial C-V.CYRIAC. M-D | ed cause of death (Hem. | 23a) (Type, I | Print) | 7, | PAS | ADEN | IA, | MD | 211. | 22 | |

State Registrar

31. Date filed (Month, Dey, Year) FEB 0 2 2000



B. Sparks

O promos B. prosing

0005 3 0 8 3 TO 60

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death **Physician** William Harry Rohrer Month 29, 2000 January 5:00 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington County 5. Social Security Number It Under 1 Yaer If Under 24 Hrs. 8. Deta of Birth Month, Day Year) Aug. 30, 1917 7. Age (In yrs. last birthdey) Funerai 214-09-9376 1**X** M 2□ F Months Deys Hours 82 Yrs. Maryland Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Washington Co. Hagerstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21523 Leitersburg/Smithsburg Road 21740 U.S.A. Funeral or items 12. Wes Decadant Evar in U,S. Armed Forces?

1 XYes 2 No 3/14/ 14. Race - Americen Indian, Bieck, White, atc. Wes Dacedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) filed within 72 hours efter 1 Never Married 2 Married 1 XYes 2 No 3 / 14 / 41 If Yes, Giva Yaer or Dates: 11 / 15 / 45 Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: 2 3 Widowad 4 □ Divorced "natural", Completed 15. Decadent's Education (Specify only highast grede complated) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) Maintenance Door Company 12 should be filed w h and Mentel Hygier I is marked other th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Harry Martin Rohrer, Sr. Lucy Alice Palmer 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 a Department of Health ar Important: if Item 27 le eny injury or other trau Pat A. Rohrer/Daughter 1002 Queen Anne Court, Hagerstown, Maryland 21740 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel trom State Mountain View Cemetery Feb. 2 Sharpsburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name and Address of Facility
Douglas A. Fiery Funeral Home 27a. Perf 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or happy feilure. List only one ceuse on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Approximete Interval Batween Onset end Deeth **Physician** CORONARY OCC/USION

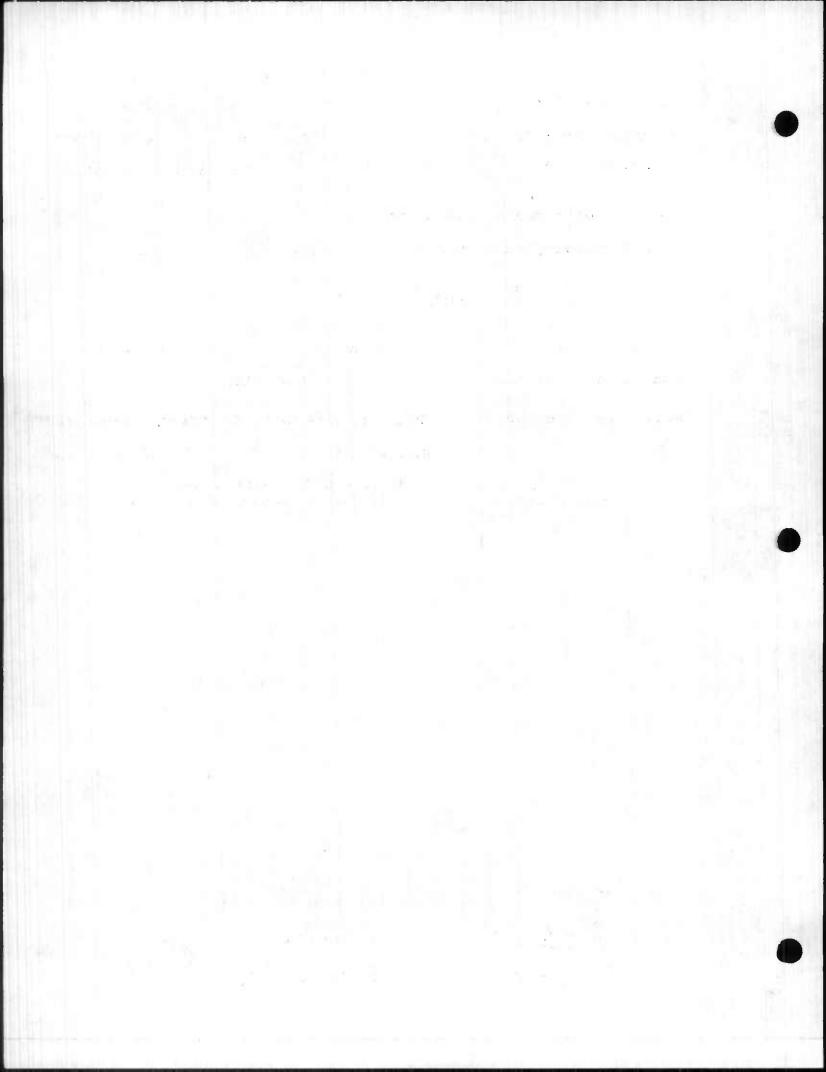
Due to (or es e consequençe ot): /Medical Immediata Ceuse (Finel 50 1004 diseese or condition resulting in deeth) Examiner Physician/Medical Examiner AThoros derusas The lew requires that the death certificate be executed physician end Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Box 68760, use as the Due to (or es e consequence ot): P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Records, þ 24b. Were autopsy findings evalleble prior to completion of causa of deeth? Completed 24a. Was an autopsy performed? page 2 s 1 Pres 2 □ No 1 Pres 2 No certificate Division of Vital or Attending Physician: Be 25. Wes cese referred to medicel exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Denpatient 2 ER/Outpatient 3 DOA ဥ 1 Yes 2 No this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral is 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide 1 Dertifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and dua to the cause(s) end menner stated. 29a. Certifier edicai (Check only onel 29b. Signeture and title of bertilled 29c. Licansa number 29d. Date signed (Month, Day, Year) 10011266 100 fonte Hagerstion, 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 38C Nevi

32. Registrer's Signeture

Registrar

State

31. Dete tiled (Month.



State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Neme | (First Middle 1 | est) | | Ce | ertificat | e of | Death | 2. Dete of De | Reg. No. | J () | 3. Time of Deeth | | |
|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------|---------------------------------------|-------------------------------------|--------------------------------------------|----------------|---------------------------------------------------------|------------------------------------|------------------------------------|-------------|-------------------------------------------------------------------------|--|--|
| Physician | | MELVIN I | | | | | | | Month | Dey | Year | | | |
| /Medical | 4a Facility Neme (# | | | - manual | | | | 4b. City, Town, or L | JANUA | | | 5:30 pm | | |
| Examiner | MALCOM | | | arrioer) | | | | CAMP SPRI | | , | | EORGES | | |
| T. constant | 5. Social Security Nu | | Sex | 7. Age (in | yrs. last birthday |) If Under | | | | | | | | |
| Funeral Director | 579-56-49 Usual Residence of I | 92 | 1∭ M 2□ F | 100 | 3 Yrs. | Months | Days | Hours Min. | MARCH | 18,194 | 6 WAS | place (State or Foreign stry) SHINGTON DO | | |
| natural, or hams 23s or 28s-f show the Engineer must be notified at steel by Funeral Director | 10s. Stete | 10b. County | TEODORG | | c. City, Town or I | | | | | | t | 0d. Inside City Limits 1 ☑ Yes 2 ☐ No | | |
| or 28a-f a | 10e. Street and Num | PRINCE (| JEUKGES | 1 | EMPLE H | 10f. Zip | Code | | | log. Citizen of What Country? | | | | |
| 0 0 | | | | | | | | | | | | | | |
| 67 a 23 | 6302 JOY | CE DK | 12, Was Dec | cedent Ever | in U.S. 13 | | 748 | Hispanic Origin? (Sc | | UNITED 3 | | San Indien, | | |
| natural, or hame 234 for Emmer ment leted by Funeral | 1 Never Merrie | | Armed F | orces? 2∭ No ive | | If Yes, spec | | Hispanic Origin? (Sp an, Mexican, Puerto Specify: | Rican, etc.) | Black, White, etc. Specify: BLACK | | | | |
| r, the Madical | (Specif | 15. Decedent's E ly only highest g | |) | (Giv | edent's Usua e kind of wor DO NOT us | k done | during most of work | king | 16b. Kind of Business/Industry | | | | |
| Comp | Elementery/Secon | dery (0-12) | College (| (1-4or 5+) | | INISTE | | | | RELIGIO | ous | | | |
| e B | 17. Father's Neme (F | | 1) | | | | | 18. Mother's Nam | e (First, Middle, WILLIA | | ie) | | | |
| To | 19e. Informant's Nar | | (Type, Print) | | 19b. Mei | ling Address | (Street | t and Number or Rui | | | Stete, Zip | Code) | | |
| | FRANCHES | TER RAY | / WIFE | Ξ | 63 | 02 .109 | CE | DR. TEMPI | E HILLS | MD 20 | 748 | | | |
| or other | FRANCHESTER RAY / WIFE 20a. Method of Disposition 1 | | | | | | | | | | | | | |
| מל מו | 1 LXBuriel 2 L 4 □ Donetion 5 | | | State | RESURR | | | | 2-2-00 | CLINTO | ON, MD | | | |
| DUCE | 21. Signeture of Fun | erel Service Lice | ensee | M | DOGCII | ALEX | AND | ess of Facility ER S. POP BORO PIKE | | | W 20 | 7/7 | | |
| | 23a, Part1. Enter the shock, or heert | e disease, or cor | notications that | 1 | | | | | | | MD 20 | 747 Approximate Interval Between | | |
| been signed by the attending physician and ahould be deteched for use as the buriel-transit leted by Physician/Medical Examiner | Sequentially list con- if any, leading to immoduse. Enter Underl Cause (Disease or in that initiated eventa resulting in death) La | | b | OS_O | to (or as a conse | ast | er | y di | sease | | | | | |
| Physician/M | | | 0 | | | | | | | | 1 | | | |
| yalo | Part II. Other signific | ant conditions | contributing to d | leath but no | t resulting in the | underlying c | ause gi | ven in Pert I. | 23b. Did | obacco use co | | the cause of death? | | |
| by Ph | | | | | | | | | 10 | Yas 20 No | 3 Pro | bebly 4 Unknow | | |
| Completed | | | | | | | | | | an autopsy med? | av co | ere autopsy findings allable prior to mpletion of cause death? | | |
| Com | | | | | | | | | 10 | res 2000 | 1[| Yes 2□ No | | |
| Be C | 25. Wes case referre | ed to medical | | | | | | 26. Place of Dear | th (Check only o | nne) | | | | |
| ÷ 0 | examiner? 1 Yes 2D N 27. Menger of Death 1 Natural | 5 Pending | 26a. Dete (Mor | Inpatient of Injury oth, Day Ye | 2 ER/Outpatie | | 8c. Inju Wo | ry at | ome 5 Resident | dence 8 GOth | | y) | | |
| Certification: | 2 Accident 3 Suicide 4 Homicide | investigetic 6 Could not determined | pe 28e. Place | e of Injury - ling, etc. (S | At home, ferm, a | | | Yes 2□No | 28f. Location (: City or Tox | | per or Rura | al Route Number, | | |
| completely filled in by the funeral | 29a. Certifier (Check only one) | Certifying P | miner: On the b | pasis of exa | knowledge, dea mination and/or i | th occurred onvestigation, | et the ti | me, date and place, opinion, death occur | and due to the red at the time, | cause(a) and ma date end plece, | anner as s | tated. o the cause(s) | | |
| To the Funeral Completely filled Medical Ce | 29b. Signeture end ti | tle of centiler | er A Iliar | nner stated. | | 290 | . Licens | se number | | 29d. Date signe | d (Month, | Day, Year) | | |
| 2 | 11 | Call | D M | 10 | | 3 |) (| 16245 | | Feb. | 15+ | 2000 | | |
|) | 30. Name and address | Patel 1 | ND 5 | se of death | (Item 23a) (Type | 0 | wit | land 1 | ND-20 | 746 | | | | |
| State | 31. Date filed (Month | Day Year | 32 | Registrar'a S | Signature | | | | | | | | | |

DHMH 16 Rev 6/95

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FEE 0 1 2080

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Tima of Deeth ROBER M4 21:80005 WILLAM TAN 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 10XM 20 F Months Days Hours 578-01-8371A 97 Florida 12-29-02 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 916 E. Meadow Ct. United States 20745 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Datas: 14. Rece - American Indien, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Ricen, etc.) Black, White, etc. 1 Naver Married 2 Married Specify: Black 1 ☐ Yas 2 ◯ No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pvt. 4th Taxicab 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) William Roberts Annie (Last Name Unknown) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 916 E. Meadow Ct., Oxon Hill, Md. 20745 Nellie Lucas, Wife 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) Data 20c. Location - City or Town, Stata Muriel 2 Cremetion 3 Removel from Steta 5 ☐ Other (Specify) 4 Donation Forest Hills Cem. 1-20-00 Clinton, Md. 21. Signety of Funerel Service Licenses 22. Name end Address of Facility Ralph Williams Funeral Service 517 11th St., SE, Wash., DC 20003 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdlac or respiretory arrest, shock, or heart feilura. List only one cause on each line. Approximete Intervel Between Onsat and Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) CARCINOMA THE COLON Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to daeth but not resulting in tha underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Realdence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 5 Pending Investigation 1 Neturel

Examiner physician and the burial-transit certificate be executed

hes

this funeral

of or Attending F efter deeth.

124 hours e Hospital

To the To the T

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

by 8

Completed

Be

10

Certification:

Medical

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

or than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Manylend

with

deeth

Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiena.
Int: If Item 27 is marked other than "natural", or ite

other t

permit. Pages Depertment of Important: If it any injury or c

Physician

/Medical

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events thet initiated events resulting in death) Lest

1 Yes 2€No

1 □ Yes 2 □ No 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29e. Certifier (Check only one)

2 Accident

3 Sulcide

4 | Homicide

1 **Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner es steled.
2 **Madical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) and mannar steled. 29d. Dete signed (Month, Day, Year)

29b. Signeture end title of certifian

29c. Licansa number 545

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) 102 WISOTSKY

31. Date filed (Month, Dey, Year) 2000

6 Could not be determined

OLD LINE CENTER WALDOLF, Md. 20602 12070 M.D.

-M

Registrar

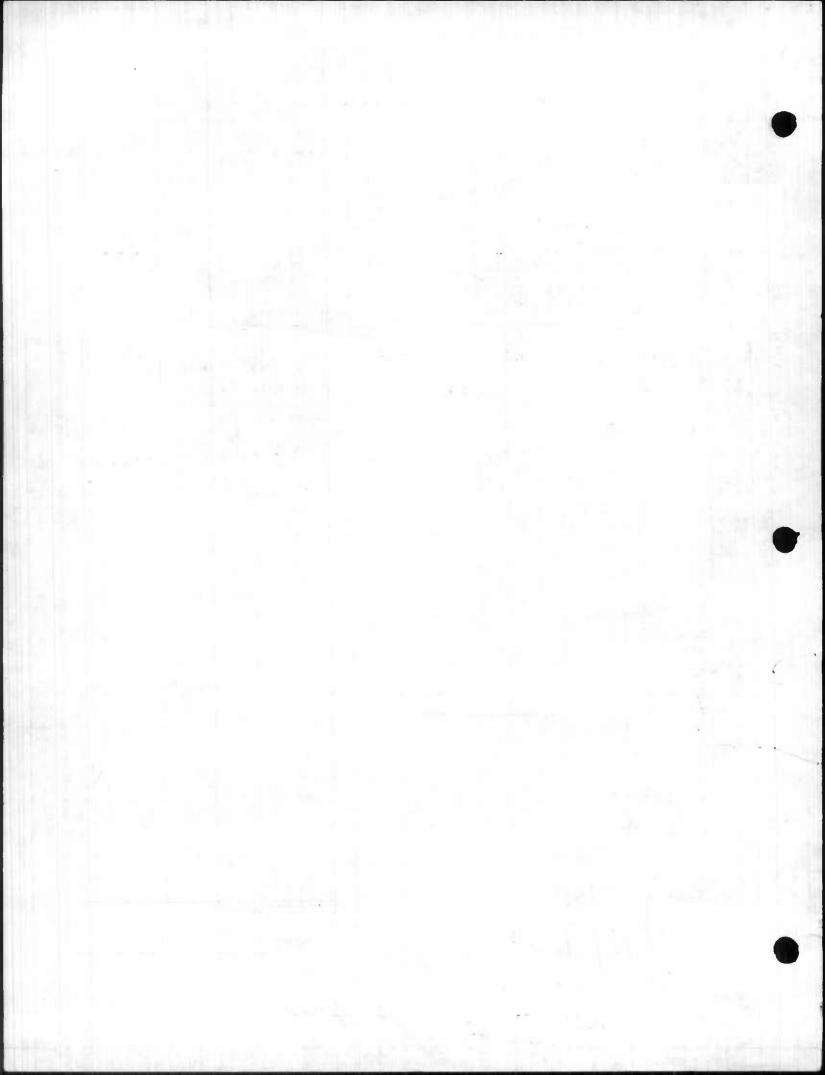
| -0637-037 | Please Type of Print in Black Indelible link. Assure All Copies Are Legi |
|-----------|--------------------------------------------------------------------------|
| JOHN | State of Maryland / Department of Health and Mental Hygiene |

| Dhusisian | 1.0 | Decedent's Name (First, Middle, Las | et) | | | | 2. Date of Deat | | | 3. Time of Death |
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| Physician | | John (| George I | Receveur, | Jr. | | Month FEBRUAR | Y 11,20 | Year | 2:10P.M. |
| /Medical Examiner | | Facility Nama (If not institution, give 24488 MERVELL DEA | | | | 4b. City, Town, or La HOLLYWOO! | | 4c. County ST . MA | | |
| Funeral Director | | Social Security Number 6. Si 212-80-0781 uat Residence of Decedent | 7. Aga (In yrs. 39 | | Under 1 Yaar onths Days | | 8. Date of Birth (Month, Day, August | Year) 3,196 | | placa (State or Forei aryland |
| 28a-f show notified at rector | | a. State 10b. County aryland St. Mary | | ty, Town or Location | | | | | | 1 ☐ Yes 2 ☐ N |
| 0 8 0 | | e. Street and Number 24488 Mervell Dea | | 10.1.1 | Of. Zip Code | 0636 | 10 | 0g. Citizen of V | Vhat Cou | |
| Examiner must Examiner must by Funeral | | . Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Dacedent Ever in U Armed Forcas? TV Yas 2 ☐ No If Yes, Giva Year or Dates: | | Decedent of s, specify Cul Yes PINO | Hispanic Origin? (Sp ban, Mexican, Puerto Specify: | | | | |
| or than "natural, the Medical. Completed | | 15. Decedent's Ed (Specify only highast grade) Elementary/Secondary (0-12) | ucation da complated) Collega (1-4or 5+) | 16a. Decedent (Give kind lifa. DO I | 's Usuat Occu t of work done NOT use retin | upation e during most of work ed) | ing | 16b. Kind of Bu | sinass/In | dustry |
| d other the event, the Be Com | | 9th Father's Name (First, Middla, Last) | N/A | Disabl | .ed | 18. Mother's Nem | a (First, Middle, A | N/ Maiden Sumam | | |
| Mont mrks To | | John George I | | | | | Claxton | - | | |
| D and 7 is m traum | 19 | Rena M. Receve | | 1 | | ervell Dear | | | | |
| Heal Mm Z Other | 204 | a. Method of Disposition | 20b. I | Place of Dispositio | n (Nama of | | | 20c. Location - | | |
| ctant: If It | 21 | 1 Burial 2 Cramation 3 4 Donation 5 Other (Specify Signature of Puneral Service Lican | Hamovai from Stata | Lee Crem | atory | reb. I | 3,2000 | | | Maryland |
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| and Litransit Examiner | ra | sulting in death) | b | | ice of): | RDIOVASCUL | AR DISEA | 15.5 | 1 | |
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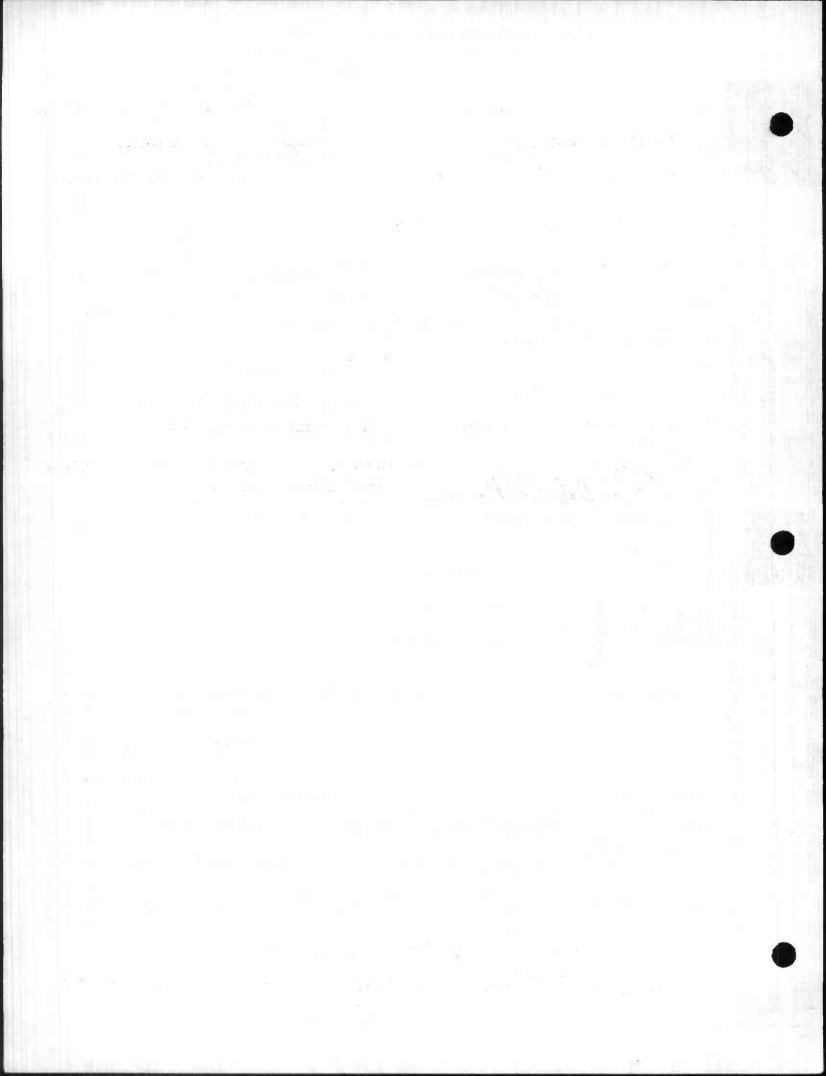
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

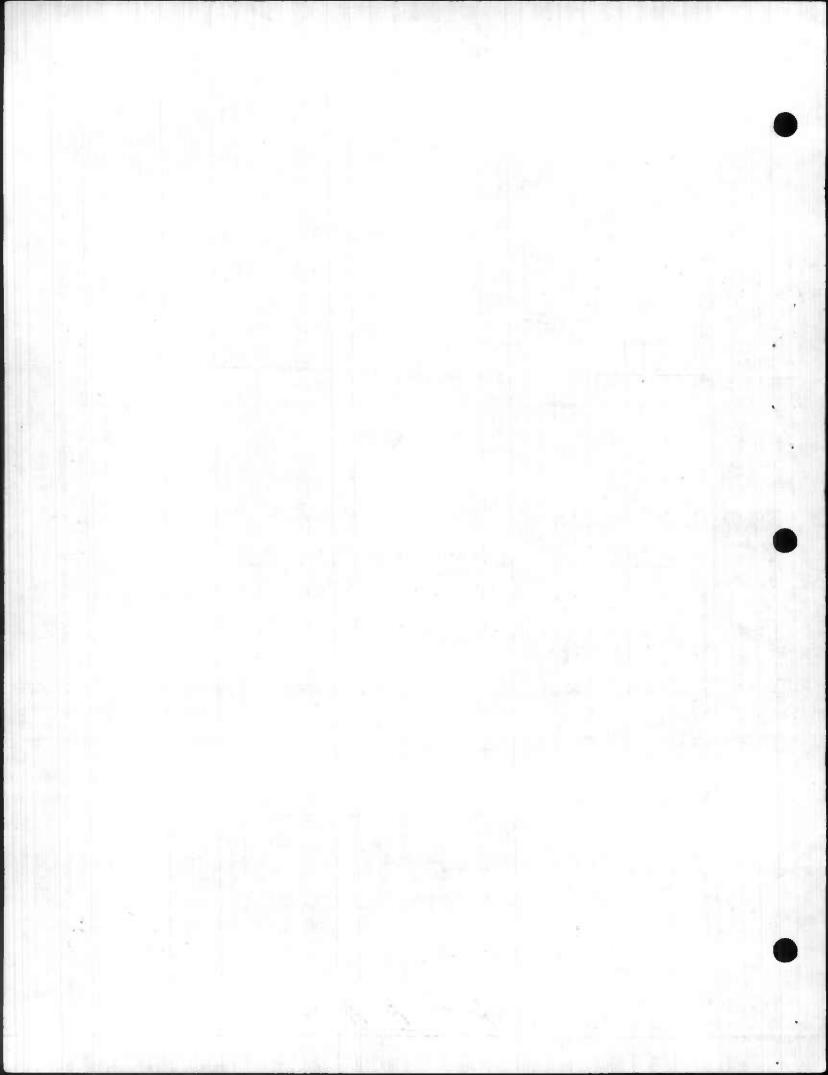
| | | | State of Mary | | rtificate of | | | Reg. No. | U | 3233 | | | | | |
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| | Physici | 0.0 | Decedent's Neme (First, Middle, Last) | | | | 2. Dete of Dee Month | eth Day | Year | 3. Time of Death | | | | | |
| J | /Media | | James Lemuel Re | ed | | | EBRUAR | | 00 | 6:25P.M. | | | | | |
| | Examir | ner | 4a. Facility Neme (If not institution, give street end number) | | | 4b. City, Town, or Lo | ocation of Deeth | 4c. County | of Death | | | | | | |
| | | | CAROLINE NURSING HOME | | | DENTON, M. | | CAROLI | | | | | | | |
| | Funeral Director | | 213-22-5860 ¹ M 2□ F | yrs. last birthdey) 72 Yrs. | Months Days | Hours Min. | 8. Dete of Birth (Month, De) July 28 | , Year) | | lece (Steta or Foreign try) /land | | | | | |
| | Pue M | | Usuei Rasidance of Decedent 10a. State 10b. County 10c | c. City, Town or Lo | ocation | | | | 1 | 0d. Inside City Limits | | | | | |
| | Marylen 4 show | 5 | Maryland Caroline | Denton | | | | | | 1 ☐ Yes 216 No | | | | | |
| | the 1 | Funeral Director | 10e, Street and Number | Dencon | 10f. Zip Coda | | | 10g. Citizen of V | /hat Coun | trv? | | | | | |
| | Sa or | Ö | Hebbs Dood | | | | | | | | | | | | |
| | death | era | Hobbs Road 11. Maritei Stetus 12. Wes Decedent Ever | in U,S. 13. | Wes Decedent of H | lispanic Origin? (Sp an, Mexican, Puarto | | United 1 | - Amaric | an Indian, | | | | | |
| 0 | r te | | 1 Never Merriad 2 Merried Armed Forces? 1 ∑ Yas 2 No] I Yes, Give | 1946- | | | Rican, etc.) | No. of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of | | | | | | | |
| 02 | all, o | b | 3 ☐ Widowed 4 ☐ Pivorced If Yes, Give Yeer or Detas:] | 1947 | 1 ☐ Yes 2 🔀 No | Specify: | | Specify | ecily: aucasian | | | | | | |
| 5-0 | 72 hc | ted | 15. Decedent's Education (Specify only highast grada completed) | 16a. Dece | dent's Usuel Occup | eation | ina | 16b. Kind of Bu | | | | | | | |
| 21215-0020 | filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or flems 23a or 28a-f show ent, the Medical Examination must be notified at | Completed | Elementery/Secondery (0-12) College (1-4or 5+) | life. | DO NOT use retired | during most of work d) | "'9 | | | | | | | | |
| 2 | filed with Hygiene. Wher than | | 9 | Tri | uck Drive | | | Milk Transportat | | | | | | | |
| and | of la b | Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | e (First, Middle, | Meiden Sumem | Θ) | | | | | | |
| Maryland | d 2 should be filed in and Mental Hygi 7 is marked other traumatic event, | To | John Amos Reed | | A 11 200 | | | lı Jones | | | | | | | |
| Ma | | | 19e. Informent's Neme/Reletionship (Type, Print) | | | end Number or Run | | | | | | | | | |
| e î | Frederick Reed Brother 1024 Market Street, De | | | | | | | 20c. Location - | | | | | | | |
| no | eges ent of t: If It | | 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Ramovei from State 4 ☐ Donetion 5 ☐ Other (Specify) | • | metory or other place | | 15 12000 | | | | | | | | |
| Baltimore, | permit. Peges Department of I- Important: If Ne any injury or of | | 21. Signature of Funeral Service Upenage | | Cemetery Name and Addra | | /6/2000 | Dento | on, Maryland | | | | | | |
| Ba | Depa Impo any i | | 21. Signature of Fineral Service Userage 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 | | | | | | | | | | | | |
| | _ | | 23a. Part1. Enter the disaesa, or complications that caused the | | Maryl | and 21629 | | | | | | | | | |
| | Physician | 1 1 | shock, or heert fellura. List only one ceuse on each line. | | , | • | | | | Intarval Between Onset and Deeth | | | | | |
| | /Medical | | Immediata Causa (Final diseasa or condition a Dementia | | | | | | | | | | | | |
| | Examiner | | mmediate Causa (Final iseasa or condition assulting in daeth) Demenute Demenute Jeans Jeans Jeans | | | | | | | | | | | | |
| | D # | Sequantially list conditions, if any, leeding to immediate Continue | | | | | | | | | | | | | |
| | ficete be executed 3 physician and as the burial-transit | хаш | Sequentially list conditions, di any, leeding to immediata | | | | | | | | | | | | |
| 68760, | be ey iclan buria | | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury | | | | | | | | | | | | |
| 587 | ficete phys s the | edical | that initiated events resulting in death) Last | i | | | | | | | | | | | |
| Box (| | | d | 1 | | | | | | | | | | | |
| ă | after of for i | clar | Deat II Other day March and Miles | vice by a to more | Control of Control | I. D. M. | 00h DI44 | Acces a reservation | | | | | | | |
| 0 | that the death cert ed by the attendin detached for use | Physician/M | Pert II. Other algnificant conditions contributing to death but not | | | /an in Part I. | | | | the cause of death? | | | | | |
| S, P | uires that the de signed by the a id be detached i | by P | cerebrovascular | acc | ike | DE | " | 2000 | 3 Pro | ALDIY 4 DIKIOWII | | | | | |
| ğ | v requires been sign should be | | | | | | 24a. Was | an autopsy med? | | are autopsy findings allable prior to | | | | | |
| of Vital Record | > 11 0 | Completed | | | | | perior | medr | COL | mpletion of causa death? | | | | | |
| T. | 0 - 5 | mo; | | | | | 1 🗆 Y | 'es 2 10 | 1 🗆 | Yes 20-No | | | | | |
| ta | | Bec | 25. Was case refarred to medical axeminer? | | | 28. Place of Deet | h (Check only o | ne) | | | | | | | |
| 5 | 0 m | 70 | Hospitel | 2 ER/Outpatier | nt 3 DOA Oth | ier: 4 ☑ Nursing Ho | me 5 Resid | lence 8 DOthe | er (Specif | γ) | | | | | |
| | D 0 0 | | 27. Manner of Deeth 1 ☑Neturel 5 ☐ Pending (Month, Day Yea | 28b. Tima o Injury | Wor | y at rk? | 28d. Describe h | ow Injury occurr | ed | | | | | | |
| Slo | leath. | catl | 2 Accident investigation 3 Sulcide 6 Could not be | | M 1 🗆 | Yes 2 □ No | | | | | | | | | |
| Division | il or Attending efter death. Director: After d in by the fune | Certification: | 4 Homicide datamined 28e. Piece of Injury - 4 building, atc. (Sp | | reet, factory, office | | 28f. Location (S City or Ton | Street end Numb vn, Stete) | er or Rure | I Route Number, | | | | | |
| | pital purs e mai D | | CO. Codffice | | | | | | | | | | | | |
| | Hospital 24 hours Funeral stely filled | edical | 29a. Certifiar 1□ Certifying Physician: To the bast of my (Check only one) 1□ Medical Examinar: On the basts of exament end menner steted. | | | | | | | | | | | | |
| | To the Hospital or Attend within 24 hours efter deatl To the Funeral Director: completely filled in by the | Me | 29b. Signetura end title of cartifier | | 29c. Licans | a number | T | 29d. Data signed | (Month, | Day, Year) | | | | | |
| | ⊢ s ⊢ ö | | I James Sasas | - M | DS | 127/ | - | 2-3- | 00 | | | | | | |
| | | | 30. Neme and eddress of person who completed cause of deeth | (Item 23a) (Type | Print) A | 112/6 | | -, -, | | | | | | | |
| | | | James Siles | 920 / | Marko | t S | + Do | 2-3- | DU | MQ | | | | | |
| | Sta | te | 31. Dete filed (Month, Day, Year) FEB - 4 2000 32. Pégistrer's S | | | | | | | | | | | | |
| | Registr | ar | FED = 4 ZUUU | D. | Spark | 2 | | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 0 0 5 2 6 0

| | | | | | Certifi | cate of | Death | F | leg. No. | 0 | 0200 |
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| Physici | an | 1. Decedent's Name (First, Middle, | | | | 500 | ITH | 2. Data of Dea Month | th Day | Year | 3. Tima of Death |
| /Medic | | SAUNDRA | Jo | | | 214 | | JANUA | | 2000 | 0303 |
| Examin | er | 4a Facility Nama (If not institution, | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | |
| <u> </u> | М | SHADY GROV | | | | Under 1 Year | ROCKY | VILLE | MO | NTGO | |
| Funeral Director | | 5. Social Security Number 207-32-3090 Usuat Residence of Decedent | . Sex 1□ M 2∏ F | Aga (In yrs. last 55 | | nths Days | | | 23, 194 | 9. Birthpl Count 4 W | aca (State or Foreign |
| pu k | | 10a. Stata 10b. County | | 10c. City, To | own or Locatio | n | | | | 10 | Od. Inside City Limits |
| Many | 0 | MD Montgo | mery | | German | town | | | | | 1 Yaa 2 No |
| 28 | Director | 10e. Street and Number | | | 10 | of. Zip Code | | 1 | I0g. Citizen of V | What Count | Iry? |
| Sa o ad | 9 | 18011 Chalet Dri | ve #104 | * | | 2087 | 4 | | USA | | |
| Z 1,Z 1 5-00Z0 d within 72 hours after death with the Manyland glene. The Madical Example: must be potified at the Madical Example: must be potified at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Deceder Armed Force 1 1 Yes 20 11 Yes, Give Year or Date: | | 1 | Decedent of it, specify Cut | | Specify Yas or No- rto Rican, atc.) | | e - Amarica ek, Whita, a Whita | atc. |
| 72 hours | P | 15. Decedent's (Specify only highest | Education | 1 | 6a. Decedent's | Usual Occu | pation | odkina | 16b. Kind of Bu | usinass/Ind | luatry |
| | Completed | Elementary/Secondary (0-12) | College (1-4o | or 5+) | | | during most of wo | Jinary | 0 11 | | |
| Hygier H | S | 9 | | | HOIII | emaker | | | Own H | | |
| Maryland 21,2 d 2 should be filled with th and Mental Hyglane. 7 is marked other than traumatic avent, the | Be | 17. Father's Nama (First, Middla, La Joseph Tedeschi | st) | | | | | ma (First, Middle, ne Wanda | | ia) | |
| Reryland 21,2 2 should be filled within and Mental Hyglene. Is marked other than sumatic avent, the la | 2 | 19a. Informent's Name/Relationship | Chara Chintl | | ION MADIES AS | Idana (Chan | | | | Ctata Zia | Codel |
| Marrand d 2 sho | | Thomas A. Smith | | | | | | Aurai Routa Numbe #104 Geri | | | 20874 |
| ire, Maryland 21,21,21 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumatic avant, the state of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro | | 20a. Mathod of Disposition | | 20b. Place | of Disposition | | | Data | 20c. Location - | | |
| Galtimore, in permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other treatment. | | 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe | | | etery, cremator Clair | | | 2/5/00 | Greens | burg. | PA |
| Dalti. F Pemit. F Departm Importar any injur | | 21. Signature of Funeral Sarvice Lic | | | | | | uneral S | | | |
| | | 1 Main. 1 | 112 | 200 | | | | et Alexa | | | 2310 |
| | | 25a. Parti. Enter the diseasa, or cl chock or heart failura. List or | implications that caus | ed tha death. D | | | | | | V 21 2 | Approximate |
| Physician | | shock or heart failure. List or | ly one cause on aach | i line. | | | | | | i | Interval Between Onsat and Death |
| /Medical | | Immediata Causa (Final disease or condition | 1 | a stil. | Stan | 11/ | | | | | 1.600000 |
| Examiner | | resulting in death) | a | Due to (or as | a consequence | e of): | | | | | 100003 |
| D # | ner | | R | min | Jary | ta | ellere | | | (| 1 Day |
| ficate be executed physician and as the burlat-fransit | Examiner | Sequentially list conditions, | Ь. | Pue to (or as | a consequenc | m of): | | | | 1 | |
| ingle of | | Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury | . / | here | nou | EQ | | | | | 1 Day |
| ificate be an g physician | edical | that initiated events resulting in death) Last | C | Dua to (or as | a consequenc | e of): | | | | | - |
| A ding p | | | d | | | | | | | | |
| death certificate be assected teath certificate be assected to a for use as the burlat-transit | Physician/M | | | | | | | | | 1 | |
| at the d | ysk | Part II. Other significant conditions | contributing to death | but not resultin | g in the underl | ying cause g | ven in Part I. | 23b. Dld 1 | obacco uaa co | | the cause of death |
| | | | | | | | | 100 | res 2□ No | 3 Prot | bably 4 Unknow |
| ha taw requires that the a has been signed by the sign 2 should be detached. | d by | | | | | | | 24a. Was | en autopsv | | ere autopsy lindings |
| been si | Completed | | | | | | | perfor | med? | cor | nilable prior to mpletion of cause death? |
| The taw ate has | E C | | | | | | | | | | |
| - F & G | | OF Was seen referred to made at | 1 | | | | | | aa 2 19 No | 11 | Yas 2□No |
| | S Be | 25. Was case referred to medical examinar? 1 ☐ Yas 2 ĎPNo | Hospital: | eined all con | O. A | D 200 OI | har | eath (Check only o | | (014 | |
| 5 € € C | . To | 27. Manner of Death | 28a. Deta of In (Month, E | itien1 2 ER/ | b. Time of | DOA 28c. Inju | | Homa 5 ☐ Resid | | | 0 |
| or Attending Ph affer death. Director: Affer th d in by the funeral | Certification: | 1 SNeturel 5 Pending 2 Accident invastigat | | Day Year) | Injury K | | vk?]Yes 2□No | | 22.11 | | |
| After by the | 158 | 3 ☐ Suicide 6 ☐ Could not | 288. Place of I | Injury - At home | , ferm, street, f | actory, office | | 28f. Location (S | Treet and Numb | per or Aura | l Route Number, |
| 2 4 2 2 | ne l | 4 Homicide | building, | atc. (Specify) | | | | City or Tow | n, Stata) | | |
| To the Hoeptal or Attends within 24 hours after death. To the Funeral Director: A Completely filled in by the fu | edical | 29a. Certifier 1 Certifying (Check only one) | Physician: To the bes | of examination | ige, death occ and/or investig | urred at the t pation, in my | ime, date end plac opinion, death occ | e, and due to the curred at the time, o | ause(s) and ma late end place, | annar as at and due to | ated. the cause(s) |
| STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STA | M | 29b. Signature and title of certifler | Hoyoen | | <u>-</u> | | se number | | 29d. Data signe | | |
| | | V/everdeste) | 1 17 m | CANS | CANICII | 174117 | 03 | 0102 5 | ANUA | 24 3 | 30 2000 |
| 11/ | | 30: Name and address of person wh | o completed cause of | death (Item 23 | a) (Type, Print |) | | - IV | - 1 1 | | |
| UNI | | URENDM U - 31. Date filed (Month, Day, Year) | SAFENA | ,7100 | | CROS | ISING C | 7, 1387 | HES DN | Mi | 30 2000 |
| Sta Registra | | FFB 1 | | Suar's Signatura | Ø. | 100 | rks | | | | |

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month **Physician** 7, 7600 Charlotte Ilene Stewart Feb 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 964 Sidesaddle Trail Lusby Calvert If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 14 1931 Birthpleca (Stata or Foreign Country)
 Ohio 5. Social Security Number 7. Aga (In yrs. last birthdey) **Funeral** Deys Hours 1 M 2 F 288 28 1092 68 Yrs. Director May Usuel Residence of Decedent 10a. Stata 10c, City, Town or Location 10d. Inside City Limits worle notified at 1 Yes 2 No Directo Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "naturel", or items 23s or the Medical Examiner must be 964 Sidesaddle Trail 20657 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status permit. Pagas 1 and 2 should be filed within 72 hours after of Department of Health and Mantal Hygians. Important: If frem 27 is marked other than "naturel", or than eny injury or other traumatic avent, the Medical Example 1 Yes 2 No ff Yes, Give Yaer or Detes: 1 Naver Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: white p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th clerk Hardware Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Roy Nadolson Mary Roffey 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) same as #1019e. Informent's Neme/Reletionship (Type, Print) Vickie Lovelady- daughter 20b. Plece of Disposition (Nema of cematary, cremetory or other place) Feb 20e. Method of Disposition 20c. Location - City or Town, Steta 2000 Buriei 2 ☐ Cremetion 3 ☐ Removel from State Newark Memorial gardens Newark Ohio 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama end Address of Fecility Rausch Funeral Home PA Rd. Port Republic, MD 206 4405 Broomes Is. 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Examiner physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Diseese or Injury that Initiated events resulting in deeth) Lest Physician/Medical Dua to (or as e consequence of): as USB 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 2 NO 1 Yes 3 Probably 4 Unknown 8 ò 24b. Were eutopsy findings avellable prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s hes 2 XNo 1 Yes 1 Yes 2 No certificata 25. Wes case referred to medicel axeminar? 26. Piace of Death (Check only one) Be Hospitei: Other: 4 Nursing Homa Residence 6 Other (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient this funeral 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury at Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of Certification: Aftar 5 Pending Neture 1 Yes 2 No Invastigetlor 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - HomicIde edical 29a. Certifie ring Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated. mar: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and dua to the cause(s) and menner steted. (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and/fittle of Feb 7, 2000 30. Neme and address of pers who completed ceuse of deeth (Item 23a) (Type, Print)

State Registrar David Gallatin,

FEB 0 7 2000

31. Dete filed (Month, Dey, Yeer)

M.D.

Prince

32. Registrar's Signety

Frederick MD 20678

with the Maryland

death

altimore, Maryland 21215-0020

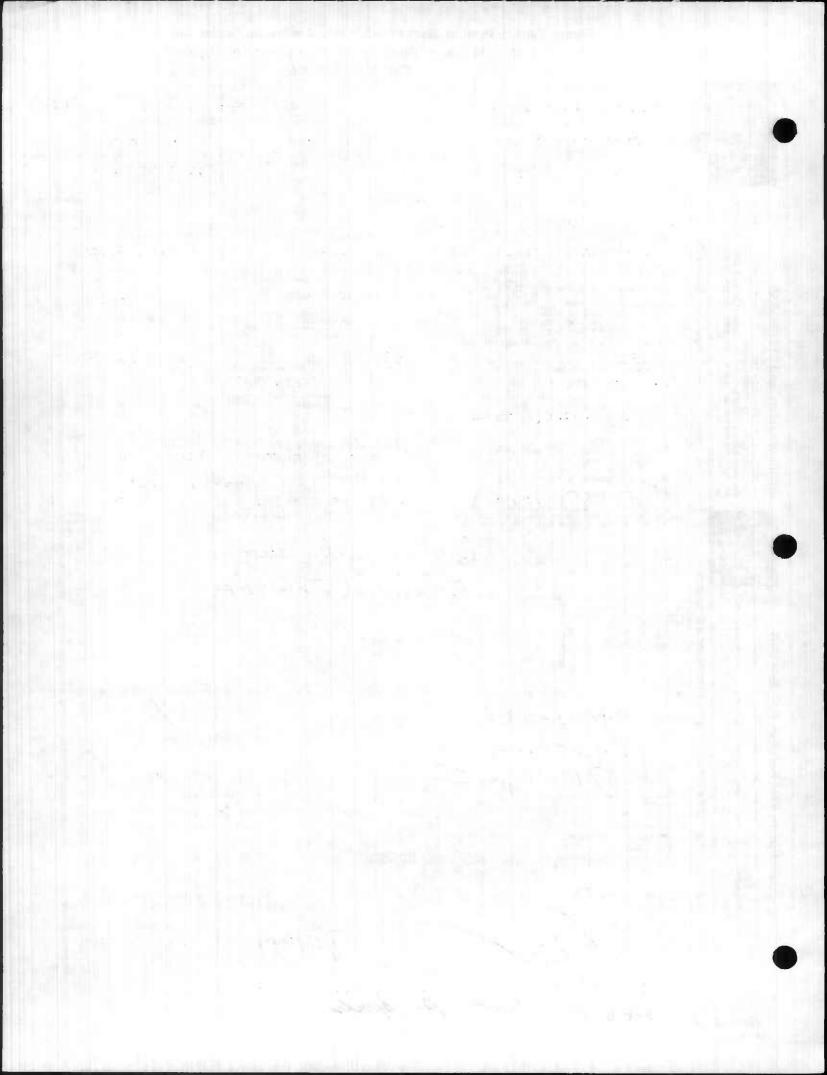
the death certificete be axed Box 68760.

P.O.

Division of Vital Records.

death.

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| | Physic /Medi | | Decedant's Nama (First, Middla, La ELWOOD SPOERL, | JR. | | | | | 2. Data of De Month | | Year 2000 | 3. Tima of Death 4:10AM | |
| | Examir | | 4e. Fecility Neme (If not Institution, giv 13056 MILLS CREH | | | | | 4b. City, Town, or L LUSBY | ocation of Death | | of Death | | |
| B | Funeral Director | | 142-24-3396 | ex 7. Age | a (In yrs. last b | Yrs. If Un | hs Days | | 8. Data of Bird (Month, Da JAN . 1 | r, Year) L, 1930 | 9. Birthplac Country PENNS | e (State or Foraign | |
| | a-f show | ctor | Usuel Rasidance of Dacedant 10a. Stete 10b. County MARYLAND CALVERT | | 10c. City, Too | wn or Location | | - | | | 10d. | . Inside City Limits 1 ☐ Yas 2 ☒ No | |
| | ours after death with the Marylan at', or frems 23s or 28s-f show Examiner must be notified at | Funeral Director | 10e. Street and Number 13056 MILLS CREI 11. Mentel Stelus | CK DRIVE | Ever in IJS | | Zip Code 2065 | 7 Hispanic Origin? (Sp | | | What Country S. A. | | |
| חסחח | n 72 hc | by | 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced | Armed Forces? 1 XYes 2 N If Yas, Giva Yaer or Datas: | ю | If Yes, s | specify Cut | oen, Mexican, Puarto | Rican, atc.) | | ck, Whita, atc | | |
| 612 | | Completed | 15. Decedent's Ec (Specify only highast gra Elementery/Secondary (0-12) | lucation da complated) College (1-4or 5 | | a. Decedant's U (Giva kind of lifa. DO NO | Isual Occu work dona Tusa retire | pation a during most of work ed) | ing | 18b. Kind of B | usinass/Indus | stry | |
| | tal Hygi | To Be Con | 12 17. Father's Name (First, Middla, Last) ELWOOD SPOERL, S | SR. | F | NGRAVEI | 3 | 18. Mothar's Neme (First, Middla, Maidan Sumama) VERONICA ERB | | | | MENT | |
| , Mai y | A | ı | 19a. informant's Name/Ralationship (BARBARA H. SPOERI | Type, Print) | | | | ot and Number or Rui | ral Route Numbe | | | | |
| | | | 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Crametlon 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specifi | | cemet | of Disposition (i ary, crematory (IERN MEN | or other plu | | NS. 11,2000 DUNKIRK, MARY | | | | |
| 3 | Department of Important: If any Injury or galde. | | 21. Signsture of Funeral Service Licer | LI | | E FUNERA | INGS, M | | | | | | |
| | hysician /Medicai | | 23a. P. 11. Entar tha disaesa, or com, or haart failura. List only | olications Wat caused ona causa on aach lin | tha daath. Do | not antar tha n | noda of dy | ing, such es cardíac | or raspiratory a | rest, | In | pproximata tarval Between nset and Death | |
| E | Examiner | Jer | diseasa or condition rasulting in daath) | a | Oua to (or as a | consequence | of): | 77000 | | _ | | Spears | |
| , | sician and burlal-transit | al Examiner | Sequantially fist conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or Injury | Dua to (or as a <i>con</i> sequance of): | | | | | | | | | |
| יייי איייי | e attending physical of for use as the l | ba | that initiated avants rasulting in daath) Lest | d | Oua to (or es e | consequence | of): | | | | | | |
| | y the | Physician/M | Pert II. Other significant conditions of | ng cause g | iven in Part I. | 23b. Did 1 | / | | ne cause of death | | | | |
| , co o o | ts been sign 2 should be | Completed by | | | | | | | 24a. Wes perfo | an autopsy rmed? | availa | autopsy findings ibie prior to liation of cause ath? | |
| | ate h | | 25. Was casa referred to medical | | | | | | | /as 2□No | 1 D Y | 'as 2□ No | |
| der Bhurlelen | h. After this funeral di | tion: To Be | axaminar? 1 Yas 2 No 27. Manner of Death 1 Netural 5 Pending | Hospital: 1 Inpaties 28a. Data of Injur (Month, Day | y 28b. | Tima of Injury | 28c. fnju | | oma 5 D Aesid | | | | |
| | ter deat frector: n by the | Certification: | 2 Accident Invastigation 3 Suicide 6 Could not be datarmined | 1 | iry - At homa, f . (Specify) | | | | 28f. Location (S City or Tow | Street and Numb m, Stata) | ber or Rural R | louta Number, | |
| Jacob e | within 24 hours after of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the f | edical | 29a. Certifiar (Check only one) | ysician: To the best of iner: On the basis of and manner sta | examination a | e, daath occurr nd/or invastiget | ed at tha ti | ima, data and place, opinion, daeth occur | and dua to tha red at tha tima, | causa(s) and modata and plece, | anner as state and dua to th | ed. a cause(s) | |
| 4 | omp of the | M | 29b. Signatura and titla of certifiar | | | | | | | 29d. Data signe | | | |
| | NV | | 30. Nema and address of person who o | complated causa of da | ath (Itam 23a) | (Type, Print) | D | 49314 | | Febr | ay 7 | ,2000 | |
| | Sta Registr | | PAUL V. POMILIA, 31. Dela filod Month Pay Year FEB 0 8 2000 | M.D. PR | | EDEBICK | MAI | RYLAND 20 | 0678 | | | | |

E . AL RUN THE RESERVE THE *i*.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Daath 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month 6:30 PM 18 2000 January Charles Paul Spahn 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Harford Joppa 728 Old Joppa Road ff Undar 24 Hrs. 5. Social Sacurity Number If Under 1 Year 8. Data of Birth (Month, Day, Year) Oct 8, 1924 9. Birthplaca (Stata or Foraign 7. Aga (In vrs. last birthday) Days 110 M 2□ F Months Hours Mary land 219-20-9589 75 Usual Rasidanca of Decedant 10c. City, Town or Location 10d. fnside City Limits 10a Stata 10h County 1 □ Yas 2 No Harford Joppa Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda USA 21085 728 Old Joppa Road 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U.S. Armed Forcas? 1 Yas 2 No 14. Raca - American Indian, 11. Marital Status Black White atc. 1 ☐ Nevar Married 2 ☑ Married If Yas, Giva Yaar or Datas: 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) Elamentery/Secondery (0-12) Collaga (1-4or 5+) Millwright Continental Canning 18. Mothar's Nama (First, Middla, Maiden Surneme) 17. Father's Nama (First, Middle, Last) Olivia Elizabeth Holzer Harry Boniface Spahn 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Jane E. Spahn/Wife 728 Old Joppa Road, Joppa, MD 21085 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State tX Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 1/24/00 Baltimore, MD Most Holy Redeemer Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvica Licanista 22. Nama and Address of Facility McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD and the death. Do not enter the mode of dying, such as cardled or respiretory arrest, 21014 23a. Part1. Enter the disease, or complication the shock, or heart failure. List only one of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the Approximete Interval Batween Onset and Death Immediata Causa (Final RESPIRATORY FAILURE disease or condition rasulting in daath) Dua to (or as a consequence of): BRONCHIOGENIC ARCINOMA Due to (or as a consequanca of): EMPHYSem A Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 1 Tas 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760

Hospital or Attending Physicien:

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show

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at

or other

Department o Important: If I any injury or

Peges 1 and 2 should be filed within 72 hours efter tent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or its

Baltimore, Maryland 21215-0020

the Menylend

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Sequantially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Diseesa or Injury thet initiated evants rasulting in death) Last

1 Yas 2 No 1 Yas 2 No

25. Was casa refarred to medical axaminar? 1 Yas 2 No 27. Manper of Death

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6 Could not be

1 Natural

2 Accident

4 Homicide

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29a. Cartifier

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Deta of Injury (Month, Dey Year) 28b. Tima of

Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred

26. Piece of Death (Check only one)

NA NA 28e. Placa of Injury - At homa, farm, straat, fectory, office building, atc. (Specify)

NA 281. Location (Street and Number or Rurel Route Number, City or Town, State)

(Check only one) 29b. Signatura and titla of certifiar

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the best of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

KNola. Here

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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 8035A HARFOLD RD BALTIMORY MD R NOUN, MD

2000 32. Registrar's Signatura 31. Data filed (Month, Day, Yaar) **JAN 21**

State Registrar



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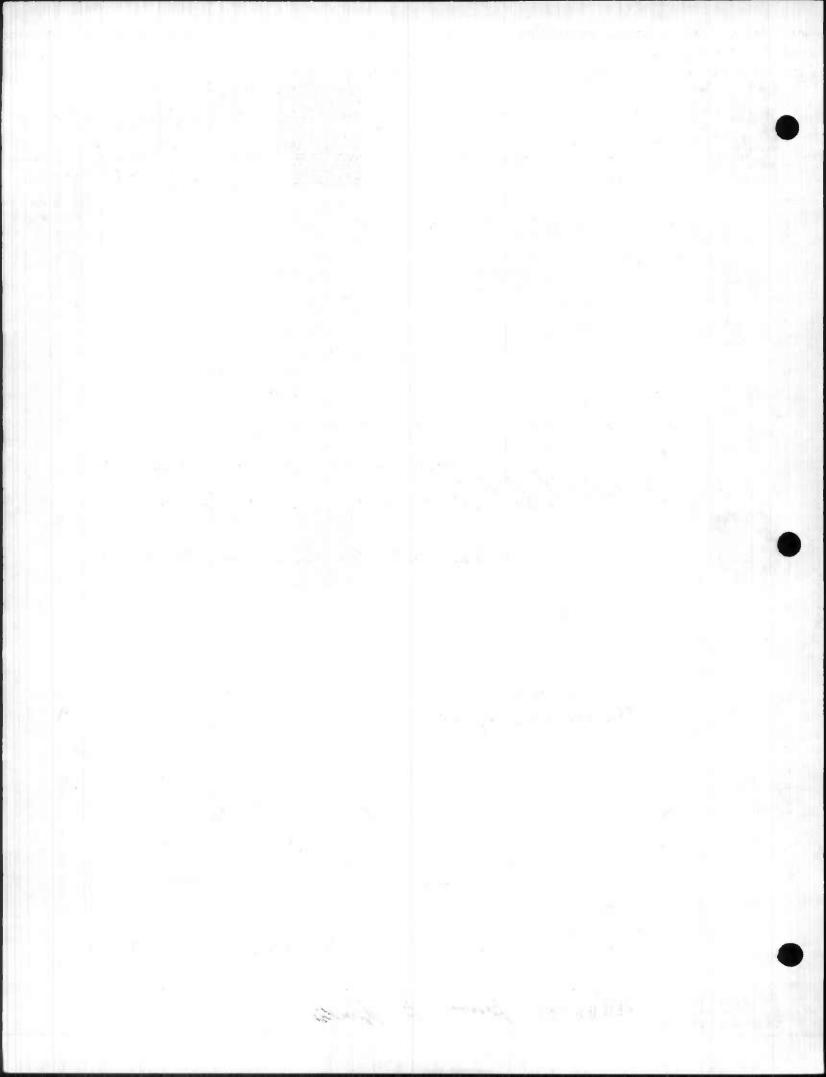
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State of Maryland / Department of Health and Mental Hygiene

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| /Med | | 4e. Fecility Neme (If not institut | | | | Shaue | 4b. City, Town, or Lo | FEBRUA | | | 2:50 AM |
| Exam | iner | | | ., | | | | | | | |
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| Funera | _ | 5. Social Security Number | 6. Sex 7. a | Age (In yrs. le: | | Months Dey | | 8. Dete of Bit (Month, Da | y, Yeer) | 9. Birthp | place (Stete or Foreign ntry) |
| Directo | 2 | 220-16-4860 | | 77 | Yrs. | | | Sept. | 11,1922 | Wash | ington, D.C |
| pu » | | Usuel Residence of Decedent 10e. Stete 10b. Cour | | 40. 00. | Town or Loc | -A! | | | | | |
| vith the Maryland or 28a-f show | | Toe. Stete Tob. Cour | .ty | TUC. City, | Town or Loc | ation | | | | 1 | Od. Inside City Limits |
| W | 용 | Maryland St. | Mary's | Mec | hanics | ville | | | | | 1 ☐ Yes 2 ➡ No |
| E 22 | Directo | 10e. Street end Number | | | | 10f. Zip Code | • | | 10g. Citizen of V | Vhet Cour | ntry? |
| index within 72 hours after death with the Maryland and diddow. In tygiene 11 hygiene 128 or 288-f show other than "natural", or items 23s or 288-f show yent, the Medical Examine must be notified at | 0 | 26195 Independ | ence Drive | | | 2065 | 59 | | United | Stat | e c |
| deat deat | e | 11. Maritel Status | 12. Wes Deceder | nt Evar in U,S | . 13. W | | f Hispenic Origin? (Spuben, Mexican, Puerto | ecify Yes or No | | | can Indien, |
| n 72 hours after dea "natural", or items | Funeral | 1 ☐ Never Married 2 ■ Ma | Armed Force arried 1 ☐ Yas 2 ₽ | | lf | Yes, specify Co | uben, Mexican, Puerto | Rican, etc.) | Bled | k, White, | etc. |
| nemit. Pages 1 end 2 should be filed within 72 hours af bepartment of Health and Mental hygiene. mportant: if Itam 27 is marked other than "natural", or nny injury or other traumatic event, the Medical Examinate. | þ | 3 ☐ Widowed 4 ☐ Divorce | If Yes Giva | _ | 1 | ☐ Yes 2 N | lo Specify: | | Specify | 7: | Black |
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| 12 should be financial hand Mental His marked of raumatic eva | 10 | Nathaniel Sha | de | | | | Maggie (| Contee | | | |
| she and | | 19a. Informent's Neme/Raletio | nship (Type, Print) | | 19b. Mailing | g Addrass (Stre | et and Number or Run | al Route Numb | er, City or Town, | Stata, Zip | (Code) |
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| s 1 end 2 should f Health and Men tam 27 is marke other traumatic | | 20e. Mathod of Disposition | | 20b. Ple | ce of Dispos | ition (Neme of | (to not) | Dete | 20c. Location - | City or To | own, Stete |
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| permit. Pages Department of Important: if Its eny Injury or o | | 21. Signature of Puneral Sept. | Mant L | 27 | 22. | Name end Add | ress of Fecility | | | | |
| 00700 | | Edward N. B | rinsfield | . M000 | 52 229 | 955 Hol | lywood Road | d. Leona | rdtown. | MD 2 | 0650-0279 |
| | | 23a. Pert1. Entar the diseese, shock, or heart feilure. Li | or complications thet caus | ed the deeth. | Do not anta | r tha moda of d | lying, such as cardiac | or respiretory a | rrest, | | Approximete Interval Batween |
| Physician | | SHOOK, OF HEALT TERRITE. EI | st only one cease on eech | | | | | | | | Onset and Death |
| /Medical | | Immedieta Causa (Final | Li |) | 1 | . 0 | | | 0 L | | |
| Examiner | | disease or condition resulting in daeth) | a. / | hero | rece | rvere | Carde | rose | way de | LONG | ? |
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| e etter | 100 | Pert ii. Other eignificant condi | tions contributing to death | but not rasult | ing in the un | derlying ceuse | oiven in Pert i. | 23b. Did | tobacco use cor | ntributa to | o the cause of death? |
| by the etten | Physician | 1 | | | - | | | | Yes 2 No | 3 □ Proi | 11 |
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| as b | Jpl | | | | | | | | Α. | of | daeth? |
| to the hospital of Atlanding Physician: The law within 24 hours effecteath. To the Funeral Director: After this certificate has a completaly filled in by the funeral director, page 2. | NO. | | | | | | | 10 | Yes 2 No | 1[| □ Yes al No |
| tifica for, p | a | 25. Wes case referred to madic | pal | | | | 26. Plece of Deet | h (Check only | ona) | 1 | |
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| The selection | - | 27, Manger of Deeth | 28a. Dete of Ir | | 8b. Time of | | | | how injury occur | | <i>y</i> / |
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| irec irec n by | Certification: | 4 ☐ Homicide deter | mined 286. PIECE OI | Injury - At hom atc. <i>(Specify)</i> | ia, tarm, stra | at, factory, offic | ×8 | City or To | Street and Numb wn, Stete) | er or Hurz | Il Houte Number, |
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| hou une ly fil | (a) | | ring Physician: To the bes | | | | | | | | |
| n 24 Ne Fi | edicai | one) | at Examiner: On the besis end menner | | n encor inve | estigetion, in m | y opinion, daam occur | red at the tima, | data and place, a | and dua te |) tria cause(a) |
| ro th | Σ | 29b. Signature and title of certif | igr . | | | 29c. Lice | nse number | | 29d. Dete signer | d (Month, | Dey, Year) |
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| | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 071 | 7 | | {, | 7.1003 | | d | 10 | |
| | | 30. Nema end eddrass of perso | n who complated causa of | daath (Itam 2 | :3a) (Type, P | rint) | | | | | |
| | | WILLIAM D.BO | YD II 2530 | | | KOUT RO | AD LEONARD | TOWN; MI | 20650 | | |
| St | ate | 31. Dete filed (Month, Day, Yaa | <i>ir)</i> 32. Regis | strer's Signetu | | - | | - | | | |
| Regist | trar | FER 0 8 | / LUUU / | | N. | Span | العا | | | | |

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05265 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** ar 105 23 2000 Jan. 8:40 P.M /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** 454 E. Broadway Street, Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Sept. 4,1924 7. Age (In vrs. last birthday) **Funeral** Months Devs Hours 1₩ 2□ F 193-18-5945 75 Yrs. Director Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 K Yas 2 No Directo Maryland 288-7 Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 21014 USA Funeral 454 E. Broadway Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Merried 8 1 ☐ Yes 2 No Specify: Specify: White å 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 to nent of Health and Mental Hygiene.
writ if Nam 27 is marked other than "national states and the states of the states and the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the states of the st Elementary/Secondary (0-12) College (1-4or 5+) Security Guard U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) 88 Britton Stoval1 Minnie Caroline Crutchfield 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Joan Parrow-step-granddaughter 824 Angel Valley Court, Edgewood, Maryland 21040 ce of Disposition (Name of Dete 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Department of H Important: If the any Injury or other Burial 2 Cremetion 3 Removal from Stete Harford Memorial Gardens 01/27/2000 Aberdeen, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Muneral Service Licenses 22. Neme and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014 mer the mode of dying, such as cerdiac of respiratory errest. 23e. Perf. Enter the disease, or complications that caused the deeth. Do not en shock, or heart failure. List only one calmo on each line. Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Lest Due to (or as Due to (or es a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaccourse gontribute to the cause of death? 1 Yea 2 No 5 3 Probably 4 Unknown been signed t þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Was an eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate funeral director. 25. Was case referred to medicel axamider? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 yes 2 No 2 ER/Outpatient 3 DOA this 27. Mannal of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending Investigation 1 Tes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 2 Accident the 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide completely filled 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be asscuted Division of Vital Records, Attending Physician:

hours after

Saltimore, Maryland 21215-0020

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State Registrar

29b. Signeture end title of certifier

of person

3. Registrer's Signetu Dey, JAN 2 7 2000

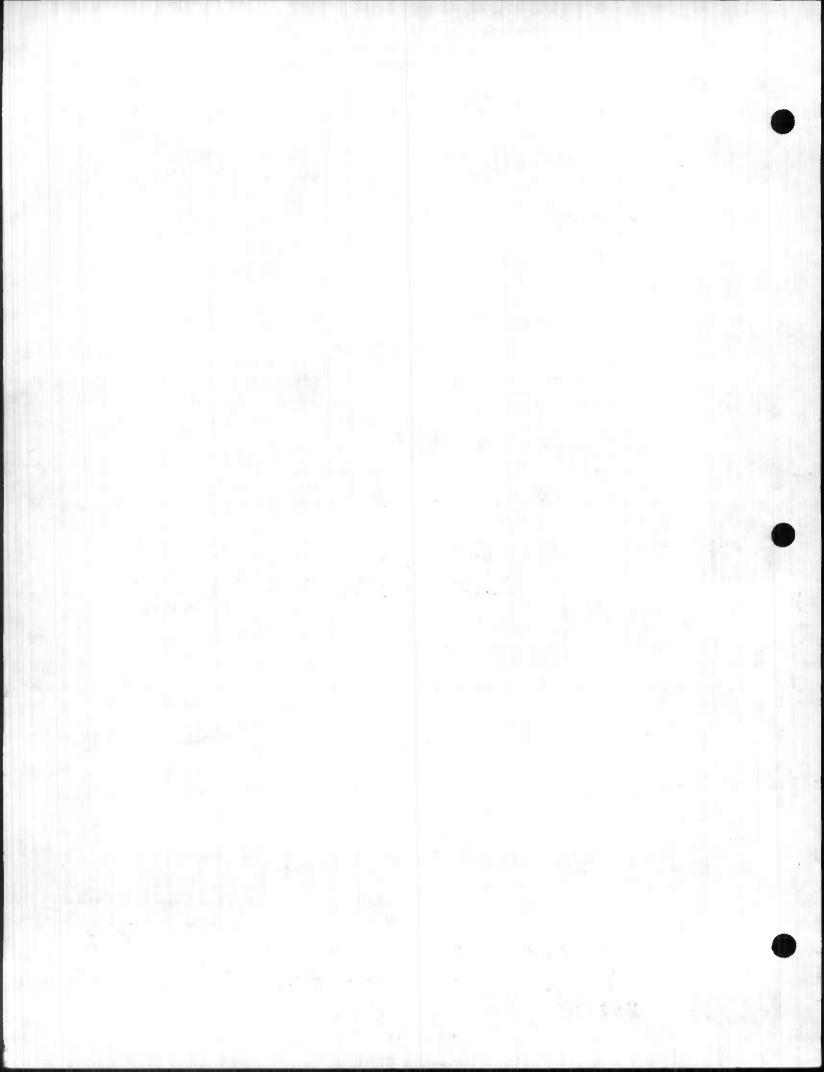
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who completed cause of death (Ite

29c. License number

29d. Date-signed Mount. Dev. Year)

23/a) (Type, Prin



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month Year Physician 1135 AM 25 2000 Arthur Marine Sewell, Jr. 4b. City, Town, or Location of Death /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Fallston General Hospital Fallston If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth Months Days Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Funeral Days Hours 1X) M 2□ F Months 51 Sept. 29, 1948 Director Maryland 220-50-0759 Usual Residence of Deceden the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limita 1 ☐ Yas 2 ☐No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ma 23a or 21047 USA 2412 Watervale Road Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11 Marital Status e filed within 72 hours effer de, al Hygiene. other then "natural", or flems vent, ma frace files of nems Black, Whita, etc. 1⊠ Yas 2□ No
If Yes, Giva
Year or Datas: 1967-71 1 Never Married 2 Married 21215-0020 White 1 ☐ Yas 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner & Operator Food Distributor 12 Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) .. Pages 1 end 2 should be fill tment of Health and Mental Hi tant: If Hem 27 is marked oth jury or other traumstic aven Arthur Marine Sewell, Sr. Catherine Mae Robinson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) P.O. Box 323, Fallston, MD 21047 Carol Sewell / Wife 20a. Method of Disposition 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20c. Location - City or Town, Stata 1 Durial 2 Cremeton 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or Hilltop Service Corp 2-1-00 Towson , Maryland 21. Signature of Funeral Service 22. Nama and Addrass of Facility
McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014 the control of the decided the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final IDAY ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Examiner Physician/Medical Examiner 13 CHEMIC HEART DISEASE anding physicien end use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last INSULIN-DEPENDENT DIABETES MELLITUS. 23h. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: t Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yas 2 PNo a etter over after and of the funeral of After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division Attending 1 Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 T Homicide 8 To the Hospital within 24 hours To the Funeral completely filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and dua to the cause(s) and manner as stated.

[Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier Andre Nowshouses Mo D08096 JANUARY 25,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HNDREW WONAKOWSK | MD 125 N, MAIN ST BELAIR, MODIO14

Registrar

1241

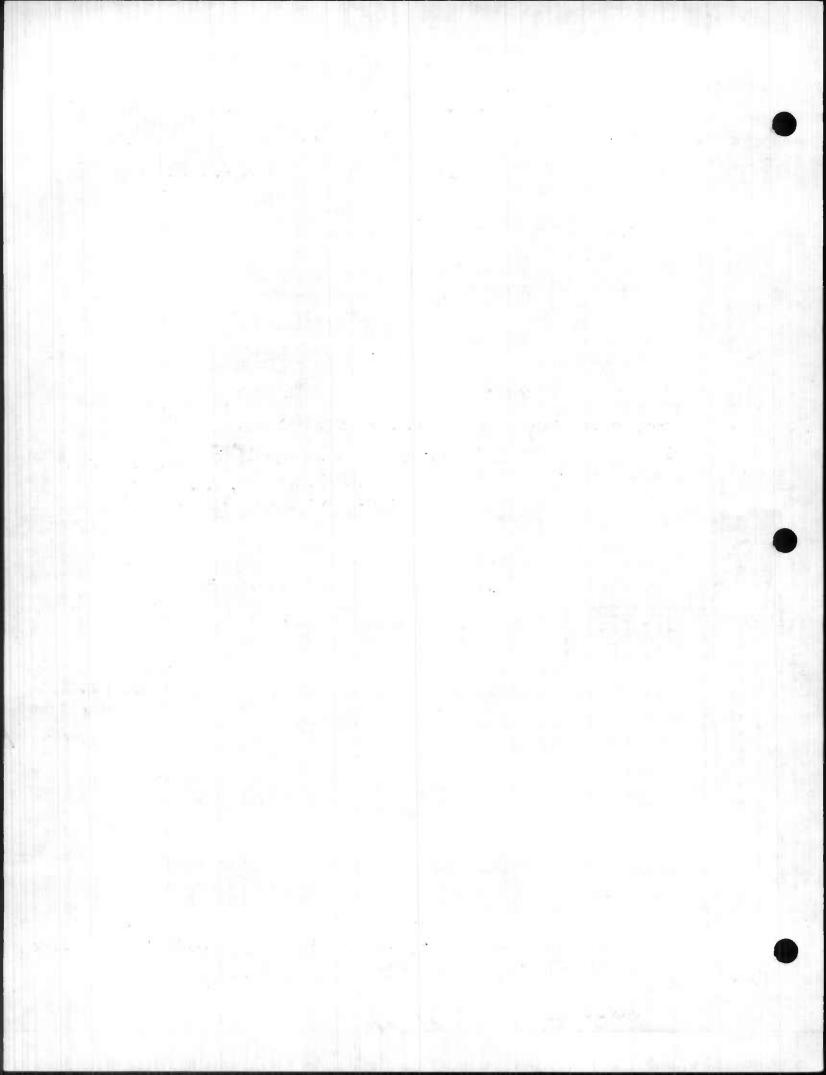
Inthur M. Sewel

DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)
JAN 2 8 2000

3. Registrar's Signetura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dele of Death 3. Time of Death Month QUIC 0510 SNeac Ednnany 1, 2000 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALSIBURY WICOMICO H Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 M 2 F 20-32-0328 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits Stoc 1 Yas 2 No Vorceste 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? George Rd 1863 Wes Decedent Ever in Y,S. Armed Forces? 1 1 1 Yes, 2 10 No If Yes, Give Year or Dates: anding Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1□Yes 2No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) gracie Ker Poultry 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SNead 101 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Girdletree 20b. Place of Disposition (Name of cemetery, crematory or other place) md. we ad Ldaughter 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Stele coolspring 25-60 Girdletree Md 4 □ Donelion 5 □ Other (Specify) 22, Name and Address of Facility Rennic Smith 21. Signature of Euneral Service Licensee Funeral Home Bennie Pocomoka City, Md. 21851 10, BOX 331 23a. Petry Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) massive Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Arterioscholor Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Funeral

Director

28a-f show

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Herna 23a

permit. Pages 1 and 2 ahould be filed within 72 hours after Department of Health and Mentel Hygiene. Important if Item 27 is marked other than "natural", or its

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Division of Vital Records,

or Attanding Physician;

this

32-032

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Director

Funeral

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Examiner ettending physician and for use as the burial-transit by Physician/Medical Completed edical Certification: To Be I Director: After ti d in by the funera To the Hospital or Attanding within 24 hours efter death.
To the Funeral Director; Afte completely filled in by the fun.

25. Was case referred to medical examiner?
12 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28d. Describe how injury occurred 28b. Time of

27. Mannel of Death 28a. Date of Injury (Month, Day Year) 1 Natural
2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 TYes 2 TNo

28t. Location (Street and Number or Rural Route Number, City or Town, State)

SALISBUM, MI

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as slated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steled. 29a. Certifier (Check only one)

29b. Signature and title of portifier

0

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) RIVERSIDE

Deepak 50999 m.s 31. Date filed (Month, Day,

32. Registrar's Signature

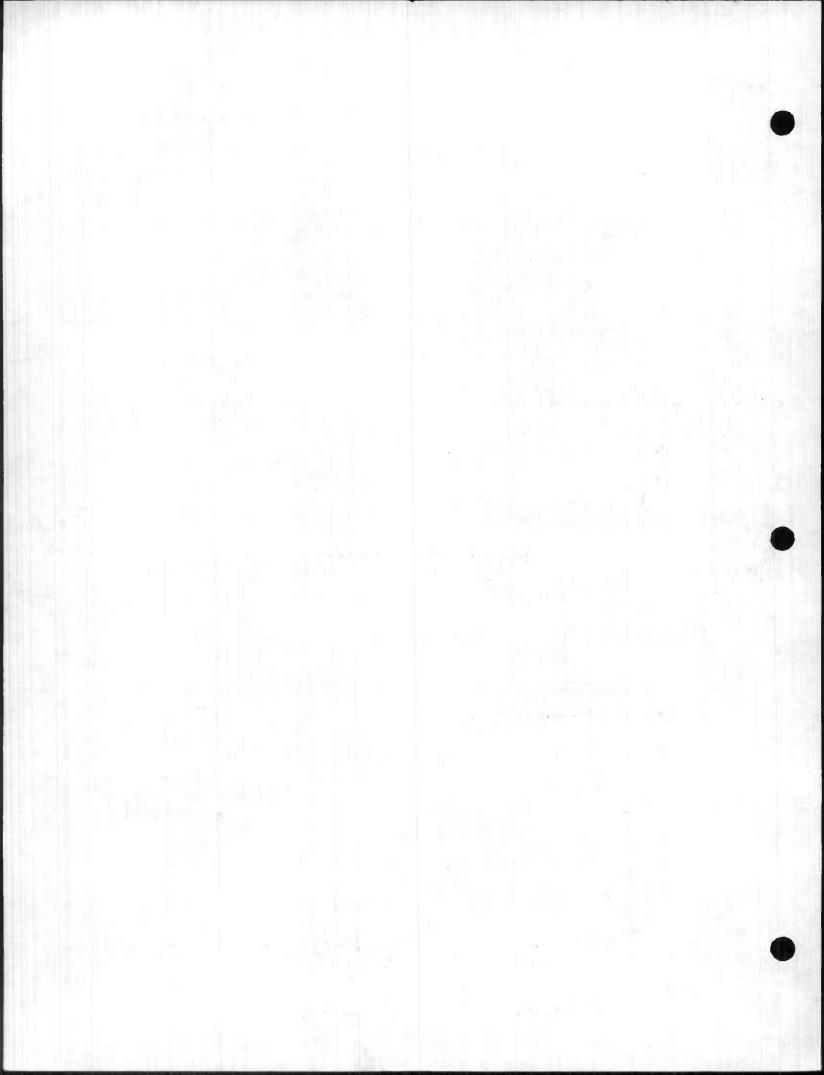
State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death Day Month Year **Physician** Jan. 30 2000 1:25 P.M. Smith Betty Elizabeth /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Queen Annes Centreville 419 So. Liberty Street If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Hours Months Days 1 M 200 F Yrs. Director Nov.13,1934 65 Maryland 214-28-1751 Usual Rasidance of Decedant The Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show. 1 X Yas 2 No Director notifie Maryland Oueen Annes Centreville 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21617 USA 419 So. Liberty Street Funeral or Itsers 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, atc permit. Pages 1 and 2 should be flied within 72 hours after to be annual to the silts and Mental Hygiene. Important if them 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examine 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced Black Yaar or Detes: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Some One else's home 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Robert Blake Nannie Baynard 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 419 So.Liberty St. Centreville, Maryland 21617 Mary Smith, Daughter 20b. Place of Disposition (Nama of cematary, crematory or other place)
Male and Female
Beneficial Lodge Cem. 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 DeBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) 2/5/2000 Centreville, Maryland 22. Nama and Addrass of Facility
Bennie Smith Funeral Home
P.O.Box 1687, Easton, Maryland 21601 21. Signature of Furieral Service Licensee Entar tha disaase, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Head + neck cencer /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner the buriel-transit or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of) USB 88 Part tt. Other algnificant conditions contributing to death but not rasuiting in tha underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 40a 2 No 3 Probably 4 Unknown Colon Carcinon~ þ 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate funeral director, Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only gna) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Assidence 6 ☐ Othar (Specify) 1 Yas 2 No edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 5 Panding invastigation 1 (PNatural 1 Yas 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicida Hospital 1 Cortifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) \$ 29b. Signature and titla of confilm 29d. Data signed (Month, Day, Year) 29c. Licanse number 0 2300 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) Pintair Drive - Suite #5, Easton, MD 21601 29444 Smith, M.D. 32. Registrer's Signature State Registrar

DHMH 16 Ray 6/95



| | | | State of Ma | aryland / I | Departmer Certificat | | | and M | , , | iene | 0 | 5269 | |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------|------------------------------------------------------|--------------------|-------------------------------|--------------------------|---------------------------------------------|-----------------------------------|------------|-------------------------------------------------------------------------|--|
| | Ohoralalaa | 1. Decedent's Name (First, Middle, Last) | | | | | | | 2. Dete of Deetl Month | h Day | Year | 3. Tima of Deeth | |
| | Physician /Medical | Alfred Andre Si | | | | | | | January | 29 2 | 000 | 6:15AM | |
| | Examiner | 4a Facility Name (If not institution, give | | | | | | | cation of Death | 4c. County | | | |
| | | Southern Maryla | | | u de la Millodo | r 1 Yeer | C1 | into | | | | eorge's | |
| | Funeral | 5. Social Security Number 6. Security Number 1577-76-5543 | M 2□F | e (In yrs. last bii 42 | Yrs. Months | | Hours | Min. | 8. Dete of Birth (Month, Day, July 20 | Year) | 9. Birthp | Nace (State or Foreign | |
| | Director | Usuat Residence of Decedent | Λ | 42 | | | | | July 20 | , 1937 | wasi | h., D.C. | |
| | or 28a-f show be notified at Director | 10a. Stete 10b. County Maryland Prince (| George's | 10c. City, Tow | n or Location | | Templ | e Hi | lls | | 1 | 0d. tnside City Limits 1 ☑ Yas 2 ☐ No | |
| | rector | 10e. Street and Number | | | 10f. Zij | Code | E11 | - | 10 | g. Citizen of W | /hat Coun | itry? | |
| | 23s or untibe r | 4711 Cedell P | lace | | | 20 | 748 | | United St | | | tates | |
| | dest frm ner | 11. Marital Status | 12. Was Decedent E Armed Forces? | ver in U,S. | 13. Was Dece | dent of F | lispanic Orig | gin? (Spe | cify Yes or No- Rican, etc.) | | - Americ | an Indian, | |
| 21215-0020 | al, or h Examina by Fu | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates: | lo | 1 ☐ Yes 2 ☐ No Specify: Spe | | | | | | | lack | |
| 5.0 | ad within 72 ho ygiene. ar than "naturi r, the Medical. Completed | 15. Decedent's Educ (Specify only highest grade | cation | 16a. | Decedent's Usu (Give kind of wo life. DO NOT u | al Occup | ation | of workin | 100 | 16b. Kind of Bu | sinass/Inc | dustry | |
| 121 | mple Men | Elementery/Secondary (0-12) | College (1-4or 5 | +) | | | | | | | | | |
| | | 12th 17. Father's Name (First, Middle, Last) | | | Forkli | ft I | | | (First, Middle, N | | ernme | ent | |
| and | a second | Alfred Oliver | Ctorrowt | | | ! | | | | | , | | |
| Maryland | d Mer d Mer merks merks | t9e. Intermant's Neme/Relationship (Ty | | 106 | . Melling Addres | /Ctrant | | | orEtta S | | | Codel | |
| - | and 2 a sellh an n 27 la r wer traus | Andrea M. Stewart | | ter | 8813 Hu | ntir | ng Lan | | 203, Lai | irel, M | D 20 | 0708 | |
| altimore | or oth | 20a. Method of Disposition 1 Spuriel 2 Cremetion 3 R | emoval from State | 20b. Place o camete | t Disposition (Na ry, crematory or o | me of other pla | ce) | ì | Date 20c. Location - City or Town, State | | | | |
| E | ment man | 4 ☐ Donation 5 ☐ Other (Specify) | onioval moni otalio | Linco | ln Memor | ial | Cem. | 2/ | 5/2000 | Suitla | nd, l | MD | |
| Bal | Depart Import any in | 21, Signature of Funeral Service License | | T | 22. Name as | | | S | tewart l | | | e 20019 | |
| | | 23a. Part Enter the disease, or compli shock, or heart teilure. List only or | cetions that caused | the death. Do | | | | | | | 1 | Approximete Interval Between | |
| 4 | Physician /Medical Examiner | Immediate Cause (Final disease or condition | 3. | eptic | Sho | ck. | | | | | | Onset and Death | |
| | | resulting in death) | 0 | Due to (or as a | consequence ot) | | , | | | | 1 | | |
| | executed in and intransit Examiner | | Ca | relie | genic | 51 | rock | | | | 14 | ukner | |
| | seth certificate be executed attending physician and for use as the buriel-transit claryMedical Examir | Sequentielly list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | | | | | | | | | i | | |
| 760, | sician buri | Cause. Enter Underlying Cause (Disease or injury that initiated events | oll | uli i | and | F | -and | | an Hand | | | | |
| 68 | phys to the | resulting in death) Last | | , | consequenca of): | | | | | | | | |
| Вох | nding use a | | Dur | len | ne | | | | | | | | |
| 00 | d for | Part II. Other eignificant conditions con | | 23b. Did to | bacco usa con | tribute to | the cause of death? | | | | | | |
| P.0 | that the death certification by the attending phy detached for use as the Physician/Med | 0 | Ive V | | | | | | | | | bably 4 Duffknown | |
| Records, | The law requires that the death certifical sata has been signed by the attending phy page 2 should be detached for use as the Completed by Physician/Medical | | | | | | | | 24a. Was ar perform | | EV. | ere autopsy tindings ailable prior to mpletion of cause death? | |
| Re | he law a has age 2 | | | | | | | | 10 40 | s 2010 | | Yes 2□ No | |
| | | 25. Was case referred to medical | | | | | 26 Place | of Death | (Check only one | | | 3163 20140 | |
| of Vital | Physician: The Lithis certificate he ral director, page | axaminer? | lospitel: | nt 2 ER/Ou | rtpatient 3□ D | OA Ott | JOY. | - | ne 5 Reside | | or (Specif | (v) | |
| | £ 50 | 27. Manner of Death 1 Neturat 5 Pending 2 Accident investigation | 28a. Dete of Injur (Month, Dey | | | 28c. Injui | | 2 | 8d. Describe ho | | | | |
| Division | Hospital or Attending P 24 hours after death. Funeral Director: After to stell filled in by the funeral dical Certification; | 3 Suicide 6 Could not be determined | 28e. Plece of Inju- building, etc | rry - At home, fa . (Specify) | rm, street, factor | y, office | | 2 | 281. Location (Sti City or Town | | er or Rura | al Route Number, | |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in Medical Cert | 29a. Certifier (Check only one) Certifying Physical Examir | icien: To the best of her: On the basis of and menner sta | examination an | , deeth occurred d/or investigation | at the tin | me, date and opinion, deal | d place, a th occurre | and due to the ca ad at the time, da | use(s) and ma ate and placa, a | nner as s | taled. o the couse(s) | |
| | Me Me | | | | | | | | | 9d. Date signed | (Month, | Day, Year) | |
| | A | 1 Xahra | | | C | 50 | 4,50 | 1 | | Tanus | ay . | 29,2000 | |
| | 10 | 30. Name and address of person who co | mpleted cause of de 9801 Geor | | (Type, Print) | • | | Spri | | 20902 | | -1700 | |
| | State Registrar | 31. Date tiled (Month Day, Yal) | | r's Signature | 6. do | | may. | ohir | mg, rin | 20302 | | | |
| | negional | 1 6.0 | / | | - Marie | | | | | | | | |

DHMH 16 Rev 6/95

FEB 0 2 2000

Lucy B. Wall

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 25, 2000 **Physician** Martha Spalding January 4:00 A.M. Tane /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner 11612 Tyre Street Upper Marlboro Prince George's | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Feb. 10,1931 9. Birthplece (State or Foreign Country)
On10 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 578-38-4604 68 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 11612 Tyre Street 20772 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Status Department of Health and Mental Hygiene.
Important II item 27 is marked other than "natural", or fee any injury or other traumatic event, the Medical Examine one. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifte. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry T. Litzenberger Mary E. Swigert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Joseph B. Spalding (Husband) 11612 Tyre Street Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) February 2, 2600 cation - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removel from State Maryland State Veterans Cemetery Cheltenham, Maryland 4 Dopatton 5 DOther (Specify) 21. Schature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a Part 1. Shall the disease, or complications that caused the defin. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each social social social shock or heart failure. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final Parkenson's Disease disease or condition resulting in death) Examinur Due to (or as a consequence of): Examine physician and the burlai-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to for as a consequence of: Box 68760 oertificate be Physician/Medical Due to (or as a consequence of): 2 2 8 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. B 1 Yes 212No 3 Probably 4 Unknown Division of Vital Records, ď 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? The law page 2 s certificate has 1 DYes 26% 1□ Yes XX 25. Was case referred to medical 89 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 10 1□Yes XX No 100 funeral 28s. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 28t. Injury at Work? After: 5 Pending 1 Matural 2 Accident 1 Yes 2 No investigation Hospital or Attend 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [] Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D47849 10 30. Name and address of person was completed cause of death (Item 23e) (Type, Print)

Monika 700 Old Line Center , Suite 100, Waldorf, Md. 20602 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture Registrar FEB 0 4 2000

DHMH 16 Rev 6/95

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| Director | 10e. Street and N 536] | umber l Sherif | f Rd. | | | 10f. Zip (| | 743 | | | 10g. Citizen | of What Co | |
| leted by Funeral Director | 11. Marital Status | rried 2 Marr | Armed F | 2 No live | | Was Decedent Yes, specification 1 Yes 2 | | | | ecify Yas or N Rican, etc.) | | Race - Ame Black, Whit ecity: B] | |
| led b | | 4 Divorced | t's Education | | | dent's Usual | | | | | 16b. Kind o | f Business | Andustry |
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| To B | | F. Savo | - | | | | | | | n Brown | | | |
| Lane. | 19a. Informent's I Calvin | | | | | _ | | | | | ber, City or To h., Md. | wn, State, 2074 | |
| lury or o | Calvin Savoy/Brother 3920 Kilbourne Dr., Ft. Wash., Md. 20744 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other placa) Forest Hills Mem. Gdns. 12/8/00 Clinton, Md. | | | | | | | | | | | | |
| | 4 Donation 5 Other (Specify) Forest Hills Mem. Gdns. 2/8/00 Clinton, Md. | | | | | | | | | | | | |
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Registrar

J. Laron Locke M.D.

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31. Date filed (Month, Day, Year)
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32. Registrar's Signature

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Frage to Metales of

FEB 0 4 2009

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 21,2000 Year **Physician** Catherine Doris 1:35 P.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millenium Health Care Edgewater Anne Arundel WUnder 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 90. Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1□M 2₩F Months 578-12-3519 90 Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas 2 ☐ No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21031 3832 Twin Oak Road U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status pernit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health end Mentel Hygiene. Important: If flem 27 is marked other than "natural", or ther any injury or other traumatic event. Its Mentel Institute is the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract 1 □ Never Merried 2 □ Merried specify: white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: py 3 I Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp completed) Elementery/Secondary (0-12) College (1-4or 5+) Womens Clothing 8 Seamstress 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Robert Garner Turner 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Patricia D. Dixon/caregiver 902 Crystal Rd. Edgewater, MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete W Buriel 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery January 25,2000 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Spinos) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Ft. Lincoln Funeral Home albart 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Deeth **Physician** Dehydration /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Butchin Examiner dac physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. Vasular 1 Yes 3X No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Using Homa 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27 Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Watural Director: After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Al 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital **Dertifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifie (Check only one) 94 29b. Signeture and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 34 ONEUSU 31. Date filed (Month, Day, Year)

DHMH 16 Ray 6/95

State

Registrar

FEB 0 2 2000

32. Registrar's Signeture

| Decedent's Name (First, Middle, Las Malvina M. Stev a Facility Name (If not institution, give | st) | | Certif | icate of | Death | | Reg. No. | | | |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------|------------------------|----------------------------------|-----------------------------------------|-----------------------------------------|--------------------------|-----------------|-------------------------|-----------------------------------------------|
| Malvina M. Ster | st) | | | | | | | | | |
| | | | | | | 2. Date of De Month | eath Day | Y | eer 3 | . Time of De |
| a Facility Nama // not inetitution give | | | | | | January | _ | 2000 | | 8:50 P |
| a racinty rearing (in riot institution, give | street and numb | er) | | | 4b. City, Town, or | Location of Deat | h 4c. | County of | Death | |
| Montgomery Gene | | | | | Olney | 11.5 | | ntgon | | |
| 579-09-6766 6.S | ex 7. □ M 2∏ F | Age (In yrs. la: 87 | NA DITTIONS | Under 1 Year lonths Days | If Under 24 Hrs Hours Min | | 1 th , 1991 | 2 F | enns | y Ivani |
| Jsual Residence of Decedent Oa. State 10b. County | | 10c City | Town or Locati | ion | | | | | 10d | Inside City I |
| | | | ington | | | | | | 100. | 1 X Yes 2 |
| Washington,DC | | Wasi | | | | | 10- 04 | zen of Wha | ot Country | - |
| Oe. Street and Number 5014 3rd Stree | t NW | | | 20011 | | | U.S | | at Country | |
| 1, Marital Status | 12. Was Decede | nt Ever in U,S | . 13. Was | Decedent of I | Hispanic Origin? (S an, Mexican, Pue | Specify Yes or No | D- | 14. Race - | American White, etc. | |
| 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorcad | 1 ☐ Yes 21 If Yes, Give Year or Date | No | | Yes 2 No | Specify: | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | Specify: [| | |
| 15. Decedent's Ed | | | 16a. Decedent | 's Usual Occu | pation | . 4 % | 16b. KI | nd of Busin | ness/Indus | Iry |
| (Specify only highest gra | de completed) Collage (1-4 | or 5+) | (Give kind life. DO | d of work done NOT use retire | during most of wo d) | onking | | | | |
| community cooling (0-12) | 20,000 (104) | 31/ | Homema | aker | | | Ow | n Hom | ie | |
| 7. Father's Name (First, Middle, Last) Earnest Smith | | | | | | wame (First, Middle Watson | , Maiden | Sumame) | | |
| 19a. Informant's Neme/Relationship (1 | Type, Print) | | 19b. Maiting A | Address (Street | end Number or F | Ru <i>ral Rou</i> te Numb | per, City o | r Town, St | ate, Zip Co | de) |
| Shawn Doran / F | | | | | e Way Si | | | | 2090 | |
| Oa. Method of Disposition | | | ca of Dispositio | on (Name of | | Date | | cation - Cit | | |
| 14 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | | Ft. | | n Cemet | ery Febr | | |) Brei | | |
| II. Singulure of Funeral Service Licen | PY | one! | | | ess of Facility Ft ensburg R | | | | | |
| 23a. Part1. Enter the diverse, or comp shock, or heart failure. List only | olications that cau one cause on eac | sed the death. | Do not enter to | he mode of dyl | ng, such as cardie | ac or respiratory a | arrest, | | In | oproximete terval Betweenset and Dec |
| mmediate Ceuse (Finel disease or condition | a | P | eur | ion | ia | | | | | Iwee |
| resulting in death) | | Due to (or | as a consequer | nca of): | | | | | 1 | |
| | , cer | eloro | va | aul | ar o | iccd | eu | 1 | 1 | |
| Sequentially list conditions, fany, leading to immediate cause. Enter Underlying | 0. | Due to (or | as a consequer | nce of): | | | | | t | |
| Cause (Disease or injury hat initiated events | C | Due to (or a | as a consequen | nce of): | | | | | - | |
| resulting in death) Last | | | | | | | | | 1 | |
| | d | | | | | | | | 1 | |
| Part II. Other significant conditions co | ontributing to deat | but not result | ting In the unde | rlying cause gi | ven in Part I. | | | | ibute to th | e cause of e |
| | | | | | | | s en euto | psy | comp | autopsy find ble prior to letion of cau |
| | | | | | | 1 🗆 | Yes 2 | No. | of dea | |
| 25. Was case referred to medical examiner? | | | | | 26. Place of De | eath (Check only | one) | | | |
| 1 ☐ Yes 2⊠No | Hospital: | atient 2 E | R/Outpatient | 3□ DOA Ot | her: 4 Nursing | Home 5□Res | idenca | 8 Other | (Specify) | |
| 7. Menner of Deeth | 28a. Date of I | njury Da <i>y Year)</i> | 28b. Time of Injury | 28c, Inju | ry at | 28d. Describe | how Inju | ry occurred | | |
| Natural 5 Pending Investigation | | ., | , y | | Yes 2□No | | | | | |
| 3 ☐ Sulcide 6 ☐ Could not be determined | 289. Place of | Injury At hon etc. (Specify) | ne, farm, street | , factory, office | | 28f. Location City or To | (Street ar own, State | nd Number a) | or Rural R | oute Numbe |
| | | | | | | | | | | |

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 45 thour after death.

within 45 thour after death.

The function of the first that this certificate has been signed by the ettending physician end complessly liked in by the tennest director, page 2 should be detached for use as the buffertransit

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other incurrent, the Medical Examinet must be notified and once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DA MENDHIRAT TA

31. Date filed (Month, Day; Year)
FEB 0 2 2000

32. Re



MD

PEG D 2 2000 Secret A. Johnson

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Death 3. Time of Deeth **Physician** Month Seldomridge 11:55 PM Laura D. 2000 Feb. 6 /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Rising Sun Cecil Calvert Manor Healthcare Center If Under 24 Hrs.
Hours Min.
Sept. 25, 1906 if Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2X F 93 Yrs. 194-38-8365 Director Usual Residence of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10d, toside City Limits 1 Yes 2 No Director Rising Sun Ceci1 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21911 USA 1881 Telegraph Rd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No It Yes, Give Year or Dates: 14. Rece - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Maxican, Puerto Rican, etc.) should be filed within 72 hours after nd Menta! Hygiene. merked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White by 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: if item 27 is marked oths any injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Wilmer Pyott Emily Guest 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 104, Townsend, DE 19734 Brinton Seldomridge 20b. Place of Disposition (Neme of cometery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlei 2 Cremetion 3 Removal from State 2/10 Kennett Square, PA 4 ☐ Donation 5 ☐ Other (Specify) Longwood Cemetery 21. Signature of Funeral Service Licenses #CCO202 22. Name end Address of Facility Kuzo & Gofus Funeral Home, Ltd. Kennett Square, PA

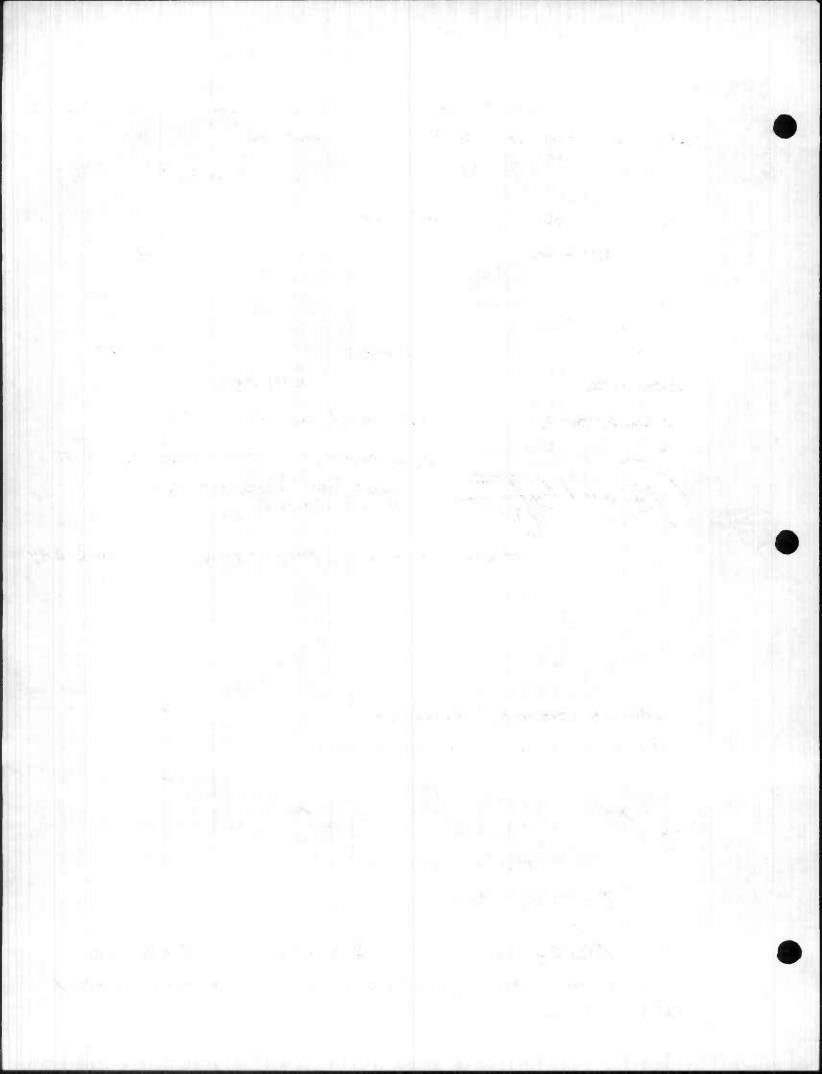
shock, or heert tellure. List only one cause on each line.

Kennett Square, PA

shock, or heert tellure. List only one cause on each line. erval Between Onset and Death **Physician** /Medical Immediete Cause (Finel ACUTE MYOCARDIAL INFARCTION ONE DAY disease or condition resulting in death) Examiner Due to (or as a consequence ot): -transit that the deeth certificate be executed Bud Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequenca ot) physician e s the buriel-Box 68760. Physician/Medical Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 2 No 3 Probably 4 □ Unknown CHRONIE ANEMIA, DEMENTIA, Records, Completed by 24b. Were eutopsy tindings availeble prior to completion of cause of deeth? 24e. Wes en autopsy performed? HYPERTENSION OSTIEDARTHRITIS 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital the Hospital or Attending Physician: thin 24 hours after death. the Funerel Director: After this certifica mpletely filled in by the funeral director, p 25. Wes case referred to medical exeminer? Be 28. Place of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Naturai 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, tarm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Discompletely filled in 12 Certifying Physicten: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certific 29c. License number 29d. Date signed (Month, Day, Year) Judhasyou D45344 30. Name end endress of person who completed cause of death (Item 23a) (Type, Print) SURESH DHAN JANI, MD, 622 S. UNION AVE, HAVRE DE GRACE, MD 21078

32. Registrar's Signeture FEB 0 8 2000 State Registrar

DHMH 16 Rev 6/95



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| an | 1. Decedent's | | · · | | | | | Month | Day | Year | |
| al er | 4a Facility Na | Rose | giva street and number) | | Scott | 4 | b. City, Town, or | Februa Location of Dea | - | 2000 unty of Death | 1139 A |
| | | on Hospita | | | | | Elkto | | | ecil | |
| | 5. Social Secu | - | | ge (in yrs. lest b | oirthday) If Undar | | If Under 24 Hr | 8. Date of B | | | place (State or Foreign |
| | 214-03 | 3-0844 | 1□ M 20 X F | 88 | Yrs. Months | Days | Hours Mir | May 1 | , 1911 | | yland |
| l | Usual Resida 10a. State | nce of Decedent 10b. County | | 10c. City. Toy | wn or Location | | - | | | | 10d. Inside City Limits |
| | Maryl | 22 1 40 2 | cil | | cton | | | | | | 1 X Yas 2 □ No |
| | 10e. Street ar | | 011 | 51.1 | 10f. Zip | Code | | | 10g. Citizen | of What Cou | intry? |
| | 466 F | Sow Street | | | | 1921 | | | Unite | ed Sta | tes |
| | 11. Marital St | | 12. Was Decedent | | | | ispanic Origin? (In, Mexicen, Pue | Specify Yas or N | | Race - Ameri | ican Indian, |
| | | Marriad 2X Marrie | Armed Forces? d 1 ☐ Yes 2 汉 if Yes, Give Year or Dates: | | 1 Yes 2 | | Specify: | no Hican, atc.) | | Black, White ecity: Wh | |
| | | 15. Decedent's (Specify only highest | Education | 166 | a. Decedent's Usua | al Occup | ation | orkina | 16b. Kind o | of Business/Ir | ndustry |
| | | /Secondary (0-12) | College (1-4or | 5+) | (Giva kind of wor life. DO NOT us | se retired | ding most of wi | Jiking | - 1 | | |
| | | (F) . A4: 41 . A | 2 | | Homema | aker | dm hd-sh-sh-hd | /phi | | er own | nome |
| | | lame <i>(First, Middle, Li</i> ed Kirk | est) | | | | | eme (First, Middl .an Hart | | meme) | |
| | | nt's Name/Relationshi | in (Type Print) | 10 | b. Mailing Addrass | (Street | | | | own State Zi | in Code) |
| | | | , Jr./Husba | | 466 Bow | | | | | | |
| | 20a. Method | | , or ./ nusba. | 20b. Place | of Disposition (Nem | ne of | | Date | 7 | ion - City or T | |
| | | ation 5 Other (Spe | 3 □Removal from State | | ery, crematory or of | | | 2/8/0 | O Cher | rv Hil | 1, Marylan |
| To Be Completed by Funeral Director | | of Funeral Service Li | | Indiac | 22. Nama and | | | 2/0/0 | o cher. | - y | z, narytan |
| | 1 | | 0 1 0 | | Hicks | | e for Fu | | | | |
| | 1 1 | market. | X - W | | | | | | | | |
| | 23a. Part1. E | inter the disease, or c | omplications that ceuse | d the death. Do | | | ockton S | | | arylan | |
| | 23a. Part1. E shock, o | inter the disease, or cor heart failure. List of | omplications that ceuse nly one cause on each li | d the death. Do | | | | | | arylan | Approximata Interval Between Onset and Death |
| | shock, o | or heart failure. List o | complications that ceuse nly one cause on each li | ine. | o not enter the mode | le of dyln | g, such as cardi | ac or respiratory | arrest, | | Approximata Interval Between |
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death January 21, 2000 January **Physician** 12:25 p.m. Marion Tsabel Skinner · /Medical 4b. City, Town, or Location of Death 4e Fecility Nema (If not institution, give street and number) 4c. County of Death Examiner Leonardtown St. Mary's St. Mary's Nursing Center If Under 1 Yaer | If Under 24 Hrs. 8. Dete of Birth

Month, Day, Year)

June 10, 1906 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign
Country) **Funeral** Months Deys Hours 1 M 2 F 081-28-3076 93 Yrs. New York **Director** Usual Rasidance of Decedani death with the Maryland v 28a-f show 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits St. Mary's Maryland Hollywood 1 ☐ Yas 2 ■ No Director 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 7 le marked other than "natural", or items 23a or treumstic event, the Medical Examinar must be a 44908 Hickory Landing Road 20636 United States Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ■ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) permit. Pages 1 and 2 should be filled within 72 hours after d Experiment of Heelth and Mental Hygiene. Important II than 27 Is marked other than "natural", or from any injury or other treumatic event, the Medical Examina-1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White by 3 ■ Widowed 4 Divorced Completed Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker n/a 18 Mother's Name (First Middle Maiden Surneme) 17 Father's Nama (First Middle Last) Ethel Harmer Harrison Hicks 2 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) Shirley A. Wilder, Daughter P.O. Box 778, Hollywood, Maryland 20636 20b. Place of Disposition (Nama of cematary, crematory or other place)
Ft. Myers Memorial Gardens 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Fort Myers, Florida 1-26-00 4 Donation 5 Other (Specify) 22. Nama and Address of Fecility Brinsfield Funeral Home, P.A. and K. Blank Blankenship, M00857 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician /Medical immedieta Causa (Final onehous disaasa or conditio rasulting in daath) Examiner Examiner certificate be executed physician and s the bunel-trans Sequentielly list conditions, if any, laading to Immadiata causa. Entar Underlying Causa (Disaasa or Injury that Initiated avants rasuiting in daath) Last Dua to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or es e consequance of): 88 980 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Completed peen page 2 certificate has 1 ☐ Yas 2 ☐ No 1 Yes 2 No 25. Was cesa rafarred to medicel axeminer? Be 26. Piaca of Death (Check only ona) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ■ Nursing Homa 5 □ Residence 6 □ Othar (Specify) P 1 Yas 2 No this funeral 27. Mannar of Daath 28a. Data of Injury (Month, Day Yaar) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? After ! Certification: or Attanding 5 Panding Invastigation 1 Natural s after death. 1 TYas 2 TNo 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) filled in by 4 Homicida Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 29a. Cartifian Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) within 2 the 29d. Dete signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number 0 M. D. D54346 21 January 2000 50 Gaber 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Registrar

31. Deta filed (Month, Day, Year)

Chandra B. Sajja, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636. 32. Pagistrar's Signatura

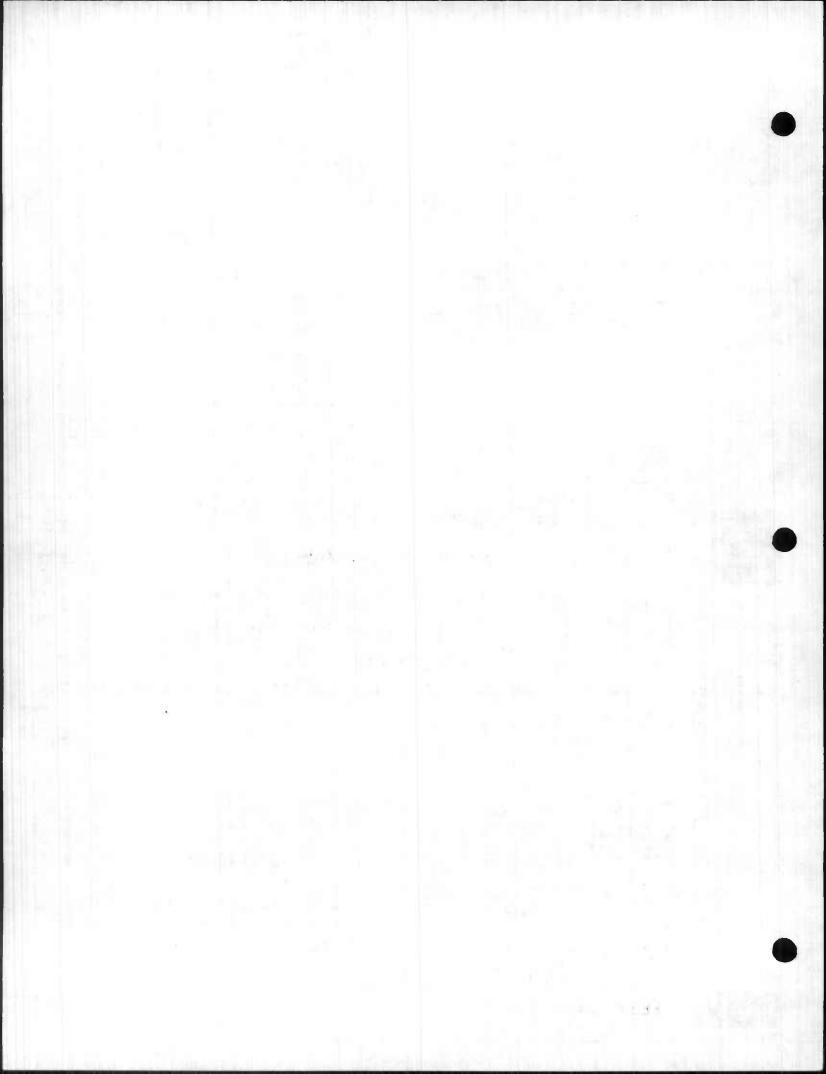
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 5 2 7 8

Certificate of Death Reg. No.

| | | | Certific | ate o | f Death | Re | g. No. | | | |
|------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------|---------------------|--------------------------------------------------------|------------------------------------------------------------------------|------------------------|---------------------------------------------|-------------------------------------------------------------------|---|
| sician | 1. Decedent's Name (First, Middle, La | Lline Sha | ffer | | | 2. Date of Death Month | Day | Year | 3. Time of Death | |
| dical niner | 4a Facility Name (If not institution, giv | | . , | | 4b. City, Town, or | Location of Death | 4c. County | 2000 of Death | 1433 | |
| iller | Union Hosp | ital | | | Elktor | 7 | Cec | 211 | | |
| | 5. Social Security Number 6. S 200-10-6565 | Sex 7. Age (In yrs | 8 2 Yrs. H Ur Mont | der 1 Yea hs Day | | | Year) / 9 / 7 | 9. Birthpla Country West | ce (Stete or Foreign Virginia | |
| | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or Location | | | | | 100 | d. Inside City Limits | |
| octor | Maryland Cecil | E | IKton | | | | | | 1 1 Ves 2 □ No | |
| Funeral Director | 10e. Street and Number 401 Marylan | d Avenue | 101. | Zip Code | 921 | 10 | g. Citizen of V | Mhal Country 5. A | | |
| þ | 11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | | cedent of pecify Cu | f Hispanic Origin? (Suban, Mexican, Puerlo Specify: | Specify Yes or No- to Rican, etc.) | Blac | e - American ck, White, etc. :: White | c. | |
| Completed | 15. Decedent's Education (Specify only highest gra | | 16a. Decedent's U | work don | e during most of wo | rking 1 | 6b. Kind of B | usiness/Indu | stry | Ī |
| mpi | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NO | Tuse reti | ned) | | -1 | 12. | - x-PACD= | - |
| ပိ | 17. Father's Name (First, Middle, Last, |) | owned | and | - | eted Store Food And BE VERALL of SName (First, Middle, Maiden Surname) | | | | |
| 0 80 | | L. Siple | | | Lola | V. Cow | | , | | |
| 트립 <u>누</u> | 19a. Informant's Name/Relationship (| et and Number or Ri | | _ | State. Zip C | Code) | | | | |
| | Henry Shaffe | -n - 50n | | ark | | Elkton | | | | |
| | 20a. Method of Disposition | 20b. | Place of Disposition (| Name of | 1 | | Oc. Location - | | | |
| ury or o | 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | JRemovel from Stete | tery | 2/8/2000 | Elkto | n, Ma | eryland | | | |
| | 21. Signature of Fundini Service Licer | | | | lress of Fecility | / / | | | | |
| | TAXAX | lel | | | main Stre | 4 | | | 1 21921 | ŀ |
| | 23a. Part1. Enter the displace, or com shock, or heart failure. List only | plications that caused the dea | | | | | | 1 1 | Approximate | |
| | shock, or neart talliare. List only | one cause on each line. | | | | | | | nterval Between Onset and Death | |
| ıl r | Immediate Cause (Final disease or condition | auto o | myocard w | tuc | Rien | | | 1 | o hois | |
| | resulting in death) | Due to | (or as a consequence | of): | 110 | | | 1 | | |
| i e | | acite | ad chrow | e (| ougestrie | Heart. | faule | - | | |
| Examine | Sequentially list conditions, | 0 | or es a consequence | | 0 | . 0 | | | | Ī |
| | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury | . Recent | t cerler | el | Vuscuile | on wife | ect | | | |
| edical | that initiated events resulting in death) Last | | or as a consequence | of): | | | | | | |
| 2 | | o. Direct | s melet | us. | | | | | | |
| clan | | | | | | | | 1 | | |
| by Physician/ | Part II. Other significant conditions of | | sulting in the underlying | g cause | given in Part I. | | , | | he cause of death? | |
| y P | Itypertersion | | | | | 1 □ Ye | a 20 No | 3 Proba | ibly 4 ☐ Unknowr | 1 |
| Completed b | | | | | | 24a. Was an perform | autopsy ed? | com | e autopsy tindings lable prior to pletion of cause eath? | |
| d L | | | | | | 4 E V 4 | of the | | | |
| | 25. Was case referred to medical | | | | OS Plans of Do | 1 Yes | 1 | 10 | Yes 2□ No | |
| To Be | examiner? | Hospital: 10 Inpatient 2 | ☐ ER/Outpatient 3☐ | DOA | Where | eth (Check only one dome 5 Resider | | er (Snecihi) | | |
| | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of | 28c. In | 4 🗆 (Adiskig F | 28d. Describe ho | | | | |
| ation | 1 Natural 5 Pending investigation | | Injury M | | /ork? ☐ Yes 2 ☐ No | | | | 100 | |
| Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At l building, etc. (Spec | home, farm, street, fac ify) | tory, offic | 9 | 28f. Location (Str. City or Town, | eet and Numl State) | per or Rural i | Route Number, | |
| Medical Certifi | | ysician: To the best of my kn niner: On the basis of examin and manner stated. | | | | | | | | |
| × | 29b. Signature end title of certifier | nse number | 29 | d. Date signe | d (Month, Di | ey, Year) | | | | |
| | I frui chit Har | ~ MD | | 20 | 4823 | | 2/4 | 20 | 70 | |
| | 30. Name and address of person who | annulated acres of doubt fla- | m 23a) (Type Print) | | | | | | | |
| | JUI CHIH HS | UMD. 22 | 3 West me | ui s | t. Ellet | on Mo | 1210 | 721. | | |
| | | | naturje / | | / | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 05279 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Sally C Saubier February 6, 2000 12:13 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Oct. 30, 1915 5. Social Security Number 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 1 M 2 X F 138-07-2249 Yrs. Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No

10f. Zip Code

1 ☐ Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10g. Citizen of What Country?

16b. Kind of Business/Industry

14. Race - American Indian, Black, White, etc.

02/07/2000

White

USA

Rising Sun

Funeral Director

Physician

/Medical

Examiner

Director

by

10a. State

Maryland

11. Marital Status

10e. Street end Number

6 Harrington Drive

1 Never Married 2 Married

3 Widowed 4 □ Divorced

Cecil

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes:

28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at filed within 72 hours after Hygiene. Ither than "natural", or ite permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien important: If Itam 27 is marked other the any Injury or other treumatic event, the page.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician and for use as the buriel-transit signed by i cartificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cardifica completely filled in by the funeral director,

P.O. Box 68760,

Records,

Division of Vital

4 State Registrar

SURESH DHAN 31. Date filed (Month, Day, Year) FEB 0 7 2000

30. Name and address of person

Completed Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John A. Wedlake Mary A. McHugh 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo F. Saubier/Son 6 Harrington Dr., Rising Sun, MD 21911 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 🕱 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockland County Cemetery 2-8-2000 Sparkhill, NY 21. Signature of Filtheral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 echand 000 23e. Part Enter the disease, or complications Mar caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximete interval Between Immediate Cause (Final ASPIRATION PNEUMONIA 4 DAYS disease or condition resulting in death) Due to (or es a consequença of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTIENSION, DEMENTIA 24b. Were autopsy findings evailable prior to Be Completed 24a. Was an autopsy performed? PARKINSON'S DISEASE completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Medical Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 5 Pending Neturel 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Piace of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and menner as stated.

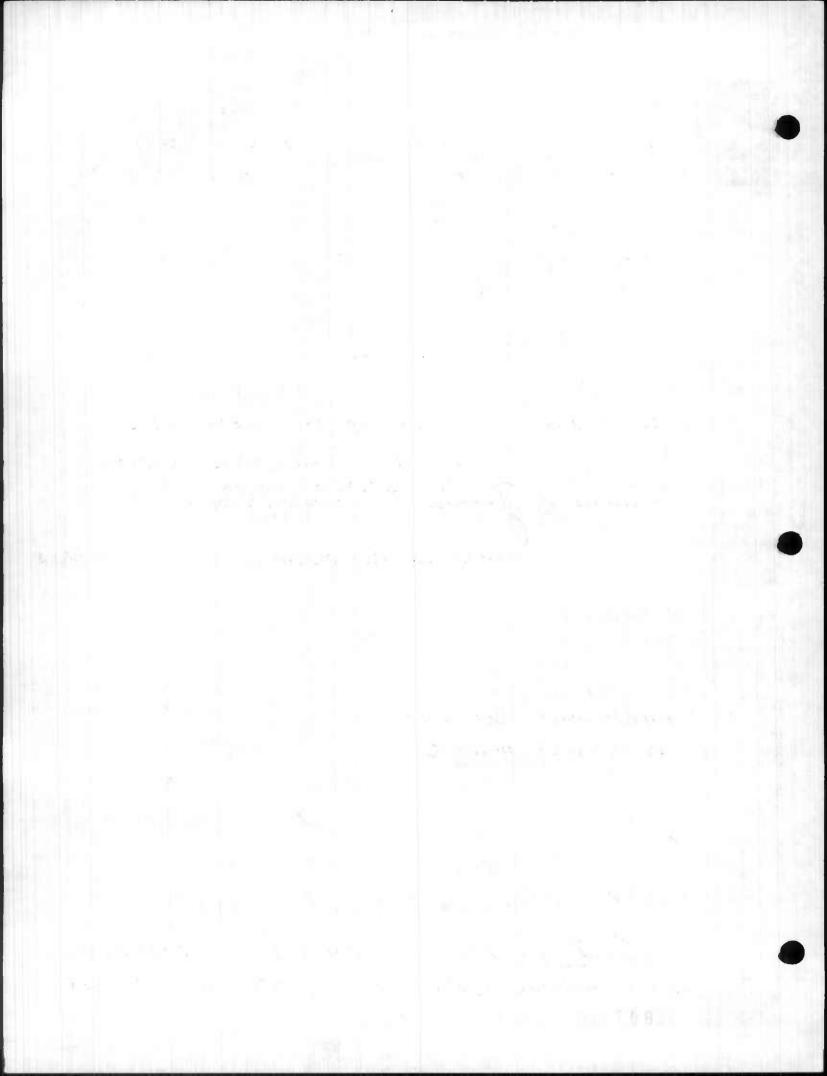
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D 45344

JANIMO, 622 S. UNION AVE, HAYRE DE GRACE, MD 21078
32. Registrar's Signature

mpleted cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95



PI

| Pleas | se Type or Pri | | | | | | • | _ | ible. | 05 | 280 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------|-----------------------------------------------|-------------------|--------------------------|----------|---------------------------------|-----------------------------|--------------------|----------|--------------------------------------------|
| | | | Certifica | te of | Death | | | Reg. No. | | | |
| 1. Decedent'e Name (First, Middle, | | rine | Ste | ver | ء ج | | 2. Date of Dea | ath Day | Year | | me of Death |
| | | | | | | | Februai | | 000 | 1 " / | 00 /11/1 |
| 4e. Facility Name (If not institution, 3143 Pine Or | chard Ln. | #201 | | 1 | Ellio | | ocation of Death | 4c. Coun | ty of Death HOV | vard | |
| 5. Social Security Number | | e (In yrs. last birt | thday) If Unde Months | r 1 Year Devs | If Under 2 Hours | | 8. Date of Birt (Month, Day | h Voor) | 9. Birth | place (S | tate or Foreign |
| 215-20-8232 | 1□M 200 F | 81 | Yrs. | Deys | nours | IVIII. | Oct 6. | | | vla | |
| Usual Residence of Decedent | | | | | | | | | 1 2 | 7 - | |
| 10a. State 10b. County | | 10c. City, Town | | 12 1 | | | | | | | ide City Limits Yes 2 No |
| Maryland Howa | I.G | EL | licott (| | | | | | | | 21 |
| 10e. Street end Number 3143 Pine Orchar | d Lane Apt. | 201 | 10f. Zi | 2104 | 12 | | | 10g. Citizen of Unit | what Cou | | S |
| 11. Marital Status | 12. Was Decedent | | 13. Wes Dece | dent of H | lispanic Orlo | in? (Sp | ecify Yes or No- | | ca - Ameri | | |
| 1 Never Married 2 Marrie | Armed Forces? 1 Yes 2 X If Yes, Give | | if Yes, spe | cify Cube | en, Mexican, Specify: | Puèrto | Rican, etc.) | | ack, White, | etc. | |
| 3 □Widowed 4 □ Divorced | Year or Dates: | 1 | | | | | | | | Whi | te |
| 15. Decedent's (Specify only highest | s Education grade completed) | 16a. | Give kind of wo | ork done | during most | of work. | ing | 16b. Kind of E | Business/Ir | dustry | |
| Elementary/Secondary (0-12) | College (1-4or 5 | i+) | life. DO NOT u | | • | | | | | | |
| unknown | | | Homen | naker | - | | | | wn Ho | me | |
| 17. Father's Name (First, Middle, L | ast) | | | | | | e (First, Middle, | Maiden Suma | m <i>e)</i> | | |
| ly Hoffman | | | | | unkn | | | | | | |
| 19a. Informant's Name/Relationshi Leonard Mark St | | | Malling Addres | | | | | | | | |
| 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of | | cemeter | Disposition (Na y, crematory or Lawn Me | other plac | | -k | Date Feb. 12 | 20c. Location | | | |
| 23a Part1. Enter the greease or c shock, or heart failure. List o | omplications that caused niy one cause on each line. | I the death. Do note. | 1331 E | s A. aste | Fiery rn Bly | Fu., | | rstown | Mary | Appro | 21742 ximate al Between and Death |
| Sequentially list conditions, fany, leading to Immediate cause. Enter Underlying Cause (Disease or injury | | Due to (or as a c | onsequence of) | | | | | | 1 | | |
| that initiated events resulting in death) Last | d. | Due to (or as a co | onsequence of): | | | | | | | | |
| Part II. Other significant condition | s contributing to death be | ut not resulting In | the underlying | ause giv | en in Part I. | - | 23b. Did t | obacco uae c | ontribute t | o the ca | use of death1 |
| Hypert | Lensin | | | | | | 101 | res 2□No | 3 Pro | bably | 4 Honknow |
| | | | | | | | 24a. Was | | av | ailable | opsy findings prior to n of cause |
| | | | | | | | 101 | es 2 3+16 | , | ☐ Yes | 2 No |
| 25. Was case referred to medical | | | | | 26. Place | of Deat | h (Check only o | ne) | | | |
| examiner? | Hospital: | nt 2 ER/Out | tpatient 3 De | Oth | er: 4 Nur | sing Ho | me 5 Resid | ence 6 🗆 Ot | her (Speci | fy) | |
| 27. Manner of Death 1 Activat 2 Accident 1 Accident | 28a. Date of Inju (Month, Day | ry. 28b. T | | 28c. Injur Wor | y at | | 28d. Describe h | | | | |
| 3 Suicide 6 Could no determin | 28e. Place of Injuding, etc | ury - At home, far c. (Specify) | rm, street, factor | y, office | | | 28f. Location (S City or Tow | itreet and Num n, State) | ber or Run | al Route | Number, |

Physician /Medical **Examiner**

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Heelih and Mental Hyglene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mendical Examines mantly notified at

Baltimore, Maryland 21215-0020

29a. Certifier (Check only one)

Physician

/Medical

Examiner

Director

Be Completed by Funeral

2

Funeral Director

physician and s the buriel-transit d for use as t within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deteched for use.

To the Hospital or Attending Physician: The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Be Completed by Medical Certification: To

Part il. Other significant cond 25. Was case referred to med 27. Manner of Death

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

Feb. 1, 2000

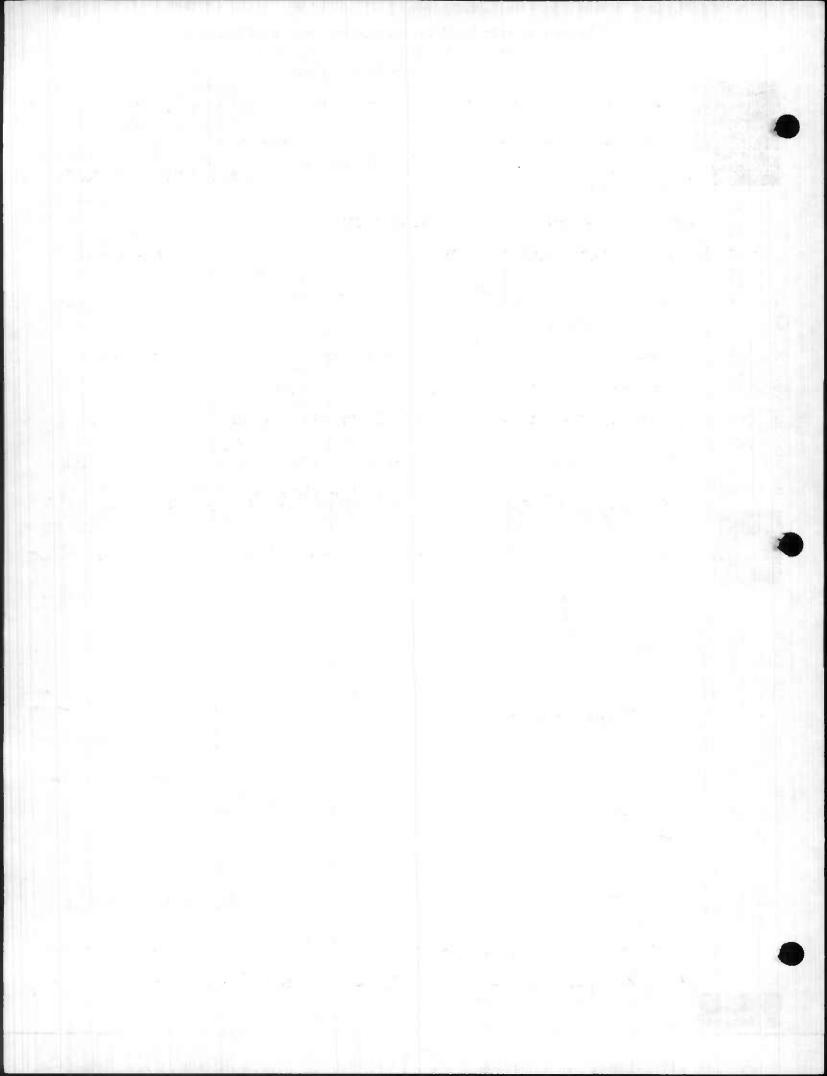
30. Name and address of person who complete leagues of death (Item 23a) (Type, Print)

Bruce M. Congel M. 205 11055 Little Palapert Plany Columbia no 2 (144)

31. Date filed (Month, Day, Year)

FEB 0 9 2000 Februare Signeture

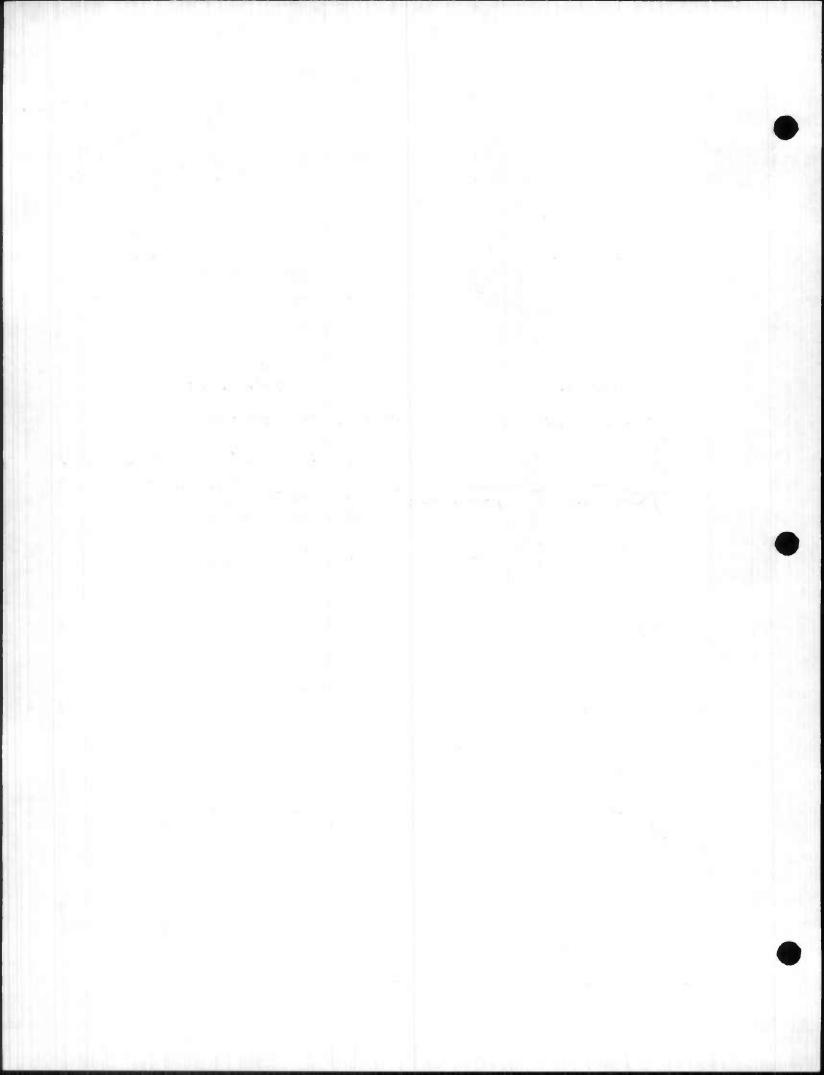
B. Sparks



1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth

| | Physici /Medi | | Lena Marie San | ders | | | | Februar | y 1, 21 | 000 | 9:10 | P.M. |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------|------------------------------------------------------------|---------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| Ĭ | Exami | | 4a. Facility Nama (If not institution, give | a street and number) | | | 4b. City, Town, or L | £ | 4c. County | | | |
| | | | Avalon Manor H | zalth Care | Center | | Hagerst | | | shing | ton | |
| 30 | Funeral Director | | 277 20 2130 | ex 7. Age ☐ M 2反 F | e (In yrs. last bir 82 | thday) If Undar 1 Yaar Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Feb. 17, | Year) 1917 | 9. Birthp Coun Mar | lace (State try) ylanc | or Foreign |
| | and w | | Usual Rasidenca of Decedent 10a. State 10b. County | | 10c. City, Tow | n or Location | | | | 1 | Od. Insida (| City Limits |
| | Meryl f ehc | Po | Md. Washing | ton | | Hagerstown | | | | | | s 2 No |
| | r 28a | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizan of V | Vhat Cour | itry? | |
| | h with | a D | 109 Holburn St. | | | 2174 | 0 | | u.s. | Α. | | |
| | deat | Funeral | 11. Marital Status | 12. Was Dacadant E Armed Forces? | Evar In U,S. | 13. Was Decedent of t | Hispanic Origin? (Spean, Mexican, Puerto | ecify Yes or No- | | e - Americ | | |
| 0700-0 | d within 72 hours after death with the Meryland liene. r than "naturel", or flems 23a or 28a-f ehow The Medical Examiner must be notified at | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☑ N If Yes, Giva Year or Dates: | ło | 1 □ Yes 2X No | | Trout, occ., | Specify | | | |
| | 72 ho | Be Completed | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16e. | Decedent's Usual Occur (Give kind of work done | pation during most of work | ina | 16b. Kind of Bu | isiness/Inc | dustry | |
| 7 | han han | mpi | Elementery/Secondary (0-12) | College (1-4or 5 | +) | life. DO NOT use retire | nd) | | | | | |
| 70 | Hygie ther t | ပိ | 17. Father's Name (First, Middle, Last) | | | Homemake | 18. Mother's Nam | e (First Middle I | Home | | | |
| Maryland | should be filed within and Mentel Hygiene. s marked other than " sumatic avent, the Wei | To Be | Boyd Wiles Sr. | | | | | e V. Dav | | | | |
| lar | 2 should and Mer is marks aumetic | | 19a. Informant's Name/Reletionship (| | | . Meiling Address (Street | | | | | Code) | |
| | of Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I He | | Vera Hartman (De | iughter) | | | | | n, Md. 21740 | | | |
| pallimore, | Peges 1 nent of H int: If iter | | 20a. Mathod of Disposition 1 | Removal from State | | Disposition (Name of ry, crematory or other pla | | eb.4. | 20c. Location - | | | |
| | rtmen rtant: | | 4 Denation 5 Other (Specify | | Green | Lawn Memori | at Park | 2000 | William | nspor | t, Md. | |
| o O | permit. Peges Department of Important: If It eny Injury or o | | 21. Signatura of Furjeral Service Licen | 500 | - | _ 22. Name and Addres _Davis Fune | | 12525 B | | | | |
| | | | 23a Part Enter the disease or com | / . / | the death Day | | | Smithsb | | . 217 | | ata . |
| | Physician | | 23a. Part1. Enter the disease, or com- shock, or heart failure. List only | one cause on each lin | ine geath. Do r | not enter the mode or dyi | ng, such as cardiac | or respiretory em | est, | | Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approxima | etween |
| | /Medical | | Immediate Cause (Final | | | 61- | IT. | | | | h m | 271 |
| | Examiner | | disease or condition resulting in death) | e | Due to (or as a | consequence of): | cottis | | | 1 | | - 10) |
| | D # | iner | _ | | | | | | | | | |
| | end end Frans | Examiner | Sequentially list conditions, | 0. | Due to (or as a | consequence of): | | | | | | |
| 00/00 | be ey | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | c | | | | | | | | |
| 000 | ficete phys | edic | that initiated events resulting In death) Last | (| Due to (or as a c | consequence of): | | | | İ | | |
| 5 | death certificate be executed e attending physician end od for use es the bunal-transit | sician/Medical | | d | | | | | | | | |
| | 0 0 0 | sicia | Part II. Other eignificant conditions of | ontributing to death bu | it not resulting Ir | n the underlying cause gi | ven in Part I. | 23b. Did to | bacco use co | ntribute to | the cause | of death? |
| ָ ֡֡֡֝ | The law requires thet the ete has been signed by the page 2 should be deteched. | Phy | Chronic obth | chin Pu | lman | , airen | | 1 🗆 Y | 00 2□ No | 3 Prot | pably 4 | 4 Unknown |
| , o | v requires that the been signed by should be detected. | by | Interio religi | ie Cardi | evene | . Dinin | | | | 045 144 | | . dra dra a a |
| 5 | requ | Completed | congertin to | ar a | her | come 1 | nten | 24e. Wes e perform | | COL | ere autopsy allable prior mpletion of | rto |
| מַ | has ge 2 : | du | arum H | spertu | wen | | | | - | | death? | |
| 0 | Attending Physician: The law or deeth. ector: After this certificate has by the funeral director, page 2 | | 25. Was case referred to medical | | | | OR Place of Pass | | s 2 No | 1 | Yes 2 | _ No |
| > | Physician: r this certific rral director, | o Be | exeminer? | Hospital: 1 ☐ Inpatier | nt 2 ER/Ou | tpetient 3□ DOA Otl | 26. Plece of Deet | m (<i>Chec</i> k only on ome 5 ☐ Reside | | or (Specifi | v) | |
| 5 | g Phy er this | n: T | 27. Manner of Deeth | 28a. Date of Injur (Month, Dey | | Tima of 28c. Inju | | 28d. Describe ho | | | 7 | |
| 5 | Attending or deeth. | atio | 1 ☑Neturel 5 ☐ Pending investigation | | 100// | | Yes 2 No | | | | | |
| 2 | or Atte | ertification: | 3 Suicida 8 Could not be determined | 28e. Place of Inju | ry - At home, fa. (Specify) | rm, street, factory, office | | 26f. Location (St City or Town | reet and Numb n, State) | er or Rura | Route Nu | mber, |
| 2 | oltal o urs af rei D | O | | | | | | _ | | | | |
| | To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu | edical | 29a. Certifier 1 ☐ Certifying Phyone) 1 ☐ Certifying Phyone | valcian: To the best o liner: On the basis of and manner sta | examination and | , death occurred at the tid d/or investigation, in my o | me, dete and place, opinion, deeth occur | and due to the co red et the time, do | due to the ceuse(s) and menner as stated. It the time, date end plecs, and due to the ceuse(s) | | | (s) |
| | withi To th | Z | 29b. Signature and title of certifiar | | | 29c. Licens | se number | | 9d. Date signe | | | |
| | | | - | nd mo | | DI | 8017 | | FEB 2 | , 2 | 0 0 0 | |
| | | | 30. Name and address of person who | | | | | | | | | |
| | -01 | 40 | Vasant Datta 31. Date filed (Month, Day, Year) | | | / / | | 1740 | | | | |
| | Sta Registr | | FEB 032 | 000 | r's Signature | B. Span | K | | | | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lloyd Stanley Spigler 305 2000 Jan /Medical 4c. County of Death 4a Facility Nama (ff not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington Hours Min. 8. Data of Birth (Month, Day, Year)

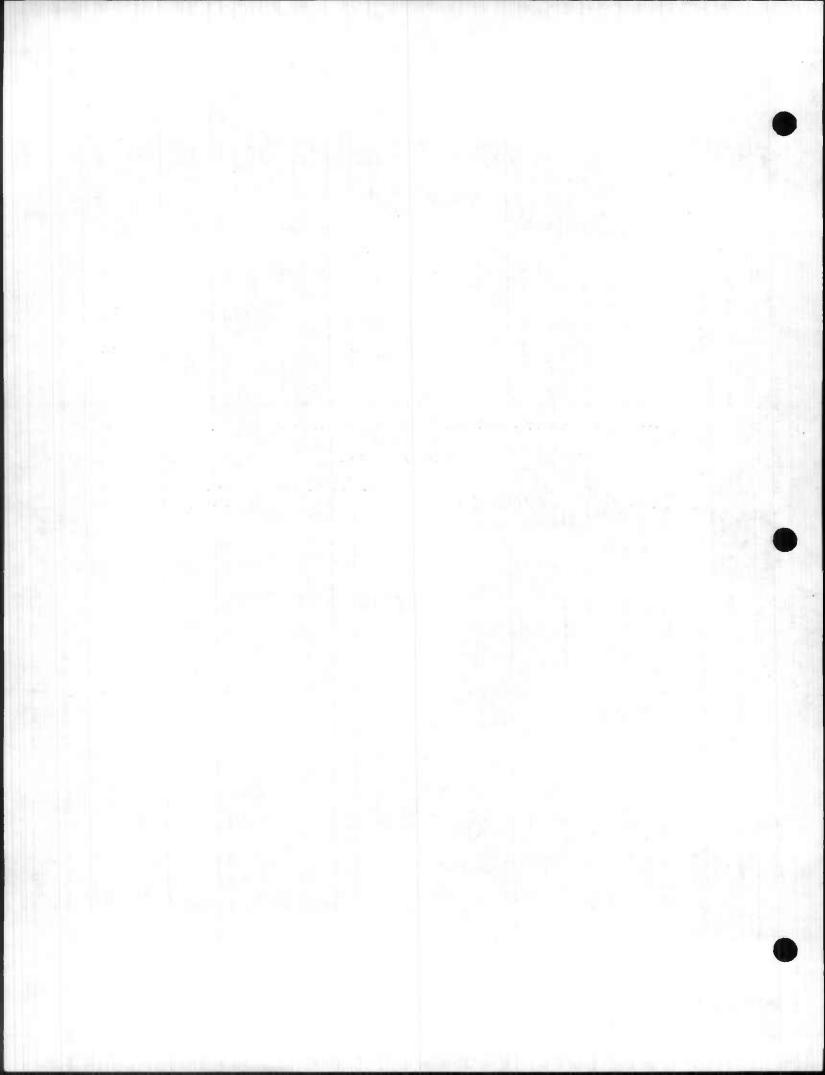
July 2, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F 212-24-7247 71 Director 1928 Maryland Usual Residence of Decedent Maryland 10a. Stata 10b. County 10c City Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1X Yas 2 No Director 280-0 å 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 509 Ridge Avenue 21740 hams 23s USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, apecify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? I Hyglane. Other than "natural", or herr Bleck, White, etc. 1X Yas 2 No If Yas, Giva Year or Datas: WW2 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 Yas ZX No Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hyglene importants if Nem 27 is marked other that any Injury or other traumetic event, the 1, 8056. installer M. P. Moller 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Jessie Nathan Spigler Ruby Viola Mays 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11321 Youngston Drive Hagerstown, Maryland 21742
lace of Disposition (Nama of Data 20c. Location - City or Town, State Carolyn M. Keesecker Friend 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State Rose Hill Cemetery 2/2/00 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name end Address of Facility Gerald N. Minnich 305 N. Potomac Street MMC 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Funeral Home Hagerstown, Maryland 21740 Approximata Interval Batween Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner Cone 100 physician and the bural-transit Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco usa contributa to the causa of death? renel disease 3 □ Probably 4 Unknown 1 Yas 2 No þ Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pege 2 t 20 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 20 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yas 2 No To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo investigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(a) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and fittle of certifier 29c. License number 29d. Data signed (Month, Day, Year) 20233 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAPURAO PULIVARTI, MD 12931 Oak hill Ave, Hagerston Mb 21742

State Registrar 31. Data filed (Month, Day, Year)

FEB 0 2 2000

32. Registrar's Signatura



| AMEND: | #4 | a per physician | State of N 1/27/0 | OAA | CO Ce | artment o | of He | ealth a leath | nd M | | giene | 0 (| 15283 |
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| | | 1. Decedent's Name (First, Middle, Las | | HEA | LTH | | | | | 2. Date of Des Month | ith | Year | 3. Tima of Death |
| | ician dical | LAURA V. | SMTTH | | | | | | | | Day 2.1 2.0.0 | | 11:55 am |
| | niner | 4a Facility Name (If not institution give | | r) | | | 4b | . City, Tov | vn, or Loc | cation of Death | | | |
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| Fune | al | 5. Social Security Number 6. Se | ex 7. A | ge (In yrs. la | | If Under 1 You Months De | ear ays | If Under 2 Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day | | | ace (State or Foreign |
| Direct | or | 216-14-5943 | □ M ZOXE | 77 | Yrs. | WOTHIS De | ays | riours | IVIW1. | | 28 192 | | RYLAND |
| 2 . | | Usual Residence of Decedent | | 1.0 00 | | | | | | | | | |
| h the Marylan r 28a-f show | - | 10a. State 10b. County | | TOC. City, | Town or Lo | OCHION | | | | | | 10 | 0d. Inside City Limits 1 N Yes 2 No |
| 2 1 | Director | MARYLAND ANNE AL | RUNDEL | ANNA | POLI | | | | | | | | |
| 201 | 듬 | 10e. Street and Number | | | | 10f. Zip Cod | de | | | | 10g. Citizen of | What Coun | lry? |
| after death w or Items 23s | 4 | | COURT | | | 2140 | | | | | USA | | |
| | Funeral | 11. Marital Status | 12. Was Deceden Armed Forces | ? | . 13. | Was Decedent If Yes, specify (| of His Cuban, | panic Orig , Mexican | in? (Spe , Puerto f | cify Yes or No- Rican, etc.) | | e - America ck, White, o | |
| | by F | 1 Never Married 2 Married 30Widowed 4 Divorced | 1 Yes 2 1 | _ | | 1□ Yes 2XI | No | Specify: | | | Specif | BLA | CK |
| 15-0020 72 hours after "natural", or ha | D D | The second second | Year or Dates | : | 10 0 | 4 4 11 -10 | | | | | 405 M'- 4 4 B | - In the second most | |
| | Completed | 15. Decedent's Ed (Specify only highest grad | | | (Give | dent's Usual Oc kind of work do DO NOT use re | one du | ion iring most | of working | ng | 16b. Kind of B | usiness/inc | ustry |
| d 2121 Hilled within Hyglene. ther than | Ę | Elementary/Secondary (0-12) | College (1-4or | r 5+) | | | , a out | | | | | | 4.03 |
| D HEE | | 17. Father's Name (First, Middle, Last) | 0 | | DOM | MESTIC. | 1 | 18. Mothe | r's Name | | OUT OF Meiden Suman | | HOME |
| ylan Suld be Mentel | Be | | | | | | | | | | | | |
| Maryland d 2 should be flie h end Mentel Hy 7 is marked oth | To | JOSEPH HALL 19a. Informant's Name/Relationship (7) | Tune Print) | | 10h Maili | ing Address (St | root ar | | | TTERS | r City or Town | Stata Zin | Code) |
| see 1 maryland 212. ges 1 and 2 should be filed within to it heelth and Mentel Hygiens. If them 27 is marked other than or other treumatic event, the | | - Service application of the Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and Service and S | IECE) | | | OWN P | | | | | | | |
| Heer de | | 20a. Method of Disposition | TECE) | 20b. Pla | ce of Dispo | osition (Nama o | w/ | | 1 . A | Date | 20c. Location | | |
| Pages nent of mt: If he | | 1 ☑Burial 2 ☐ Cremation 3 ☐ | | | | matory or other CHURCH | | | 1/ | | | | IS, MD. |
| | | 4 Donation 5 Other (Specify | | LOWI | - | | | | 1 | 31/200 | JO ANN | AFOL. | 15, 110. |
| Balt pemit. Departiment | 900 | 21. Signature of Funeral Service Licen: | See | | | 2. Name and Ad VM . REI | | | | MORTI | JARY, | P.A. | |
| _ 6024 | | Larry S. T. | Jeese | | 3 | 321 WES | ST | ST. | ANN | APOLIS | MD. | | 01 |
| | | 23a. Part1. Enter the disease, or comp shock, or heart feilure. List only of | olications that cause one cause on each | ed the death. line. | Do not en | ter the mode of | dying, | such es | cardiec o | r respiretory en | rest, | | Approximete Interval Between |
| Physicia | | Water State Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Comm | | 0 | 7 | | | 00 | | | | | Onset end Death |
| /Medic | | Immediate Cause (Final disease or condition resulting in death) | 4. | (m | mo | quence of the | 2 | den | 0 | | | ; | 1 week |
| | | Tosolieng at coeuty | | Due to (or a | as a conse | quence of): | + | , | 1 | | | | 3 years |
| 2 5 | _ e | | b | con | yestr | up rea | 4 | par | eme | | | i | Syears |
| 760, be executed sician and burlei-braneit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | Due to (or a | as a consec | quence of): | | | | | | | |
| 760, to be execut ysician end | Cal | cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | | | i | |
| 1 2 2 3 | - | resulting in death) Last | | Due to (or a | is a consec | quence of): | | | | | | i | |
| X Sentifi | Me | | d | | | | | | | | | | |
| BOX ath cert for use | lan | | | | | | | | | | | | |
| O # ## | Physician/Med | Part II. Other significant conditions co | ontributing to death | but not result | ing in the u | inderlying cause | e giver | n in Part I. | | | 1.1 | | the cause of death? |
| P.O. the that detache | 4 | morbed of | esity | | | | | | | 101 | /ea 200 No | 3 Prot | bably 4 Unknown |
| Records, P.O. Box 68 is leave requires that the death certifical that been signed by the attending phy age 2 should be detached for use as the | d by | | | | | | | | | 24a Was | en autopsy | 24b We | era autopsy findings |
| cord v require been si | Completed | | | | | | | | | perfor | med? | COL | ulable prior to repletion of cause |
| Rec lew has b | jd t | | | | | | | | | | | of e | death? |
| The The | S | | | | | | | | | 1 🗆 Y | es 2 No | 10 | Yes 2□ No |
| Of Vital Physician: The Physician: The Physician: The Physician and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederate and Confederat | Be | 25. Was case referred to medical examiner? | Managhait. | | | | | | | (Check only o | | | |
| Physic critics of religion | 2 | ILI Yes OK NO | Hospital: 1 Inpa | | R/Outpatie | | Other | 4 20 NU | | | ence 6 Ott | | 1) |
| ner P | Certification: | 27. Manner of Death Natural 5 Pending | 28a. Date of In (Month, D | lay Year) 2 | 8b. Time o Injury | | Injury a Work? | | . 10 | 28d. Describe h | ow Injury occur | Ted | |
| Division Tor Attending after death. Director: After d in by the fune | catl | Accident investigation 3 Suicide 6 Could not be | | | | М | 1 🗆 Y | es 2 l | | | | | |
| Or Att | E | 4 Homicide determined | 288. Place of II | njury - At hom etc. <i>(Specify)</i> | e, farm, sl | reet, factory, off | fice | | 2 | 28f. Location (S City or Ton | | ber or Rura | I Route Number, |
| O SEE | | | | | | | | | | | | | |
| Division of Vital Re To the Hospital or Attending Physician: The Howithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | edical | 29a. Certifier / Certifying Phy (Check only 2 Medical Exam | iner: On the basis | of examinatio | edge, deat n and/or in | h occurred at the eventigation, in n | ne time ny opii | , date and nion, deet | d place, a h occurre | and due to the co | ause(s) and m date and place, | annar as st | ated. the cause(s) |
| the pie | Med | one) | and manner s | stated. | | 200 140 | | number | | | 20d Date signs | d (Month | Day Vassl |
| 5368 | - | 29b. Signature and title of confiden | - 60 | 0 | | 29c. Lic | m | 20 | 75 | フノ | 29d. Date signe | d (Month, | Dey, Year) |
| | | | 3 M | | | U | U |) 2 | | | 1/20 | 100 | / |
| | | 30. Name and address of person who o | empleted cause of | death (Item 2 | (Type, | Print) | n | | | 4 1 | R. Be. | Ry | |
| | | 1655 (ROFTON | 1JULVI |). (* | 20F7 | ON 11 | D | الم | /// | 4 | | U | |
| | State | 31. Date filed (Month, Day, Year) JAN 2 7 2 | | rar's Signatu | 91 | 4 1 | | | | | | | |
| Regi | strar | JAN 6 / 2 | .000 | | | . 140 | The state of | 4 | | | | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) JAN 24 **Physician** 2000 2:35 pm EUGENIA J. SMITH /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS GENESIS ELDER CARE SPA CREEK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Deys Hours MARYLAND 1 M XDE Months 1921 78 Director JUNE 12 219-12-9743 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or forms 23s or 28s-f show the Medical Examiner must be notified at XVes 2□ No Director MARYLAND ANNE ARUNDEL LOTHIAN 10f. Zip Code 10g. Citizen of What Country? USA 20711 4913 SANDS ROAD deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ĈĴNo Il Yes, Give Year or Dates: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Hasilh and Mental Hyglens. Important: if them 27 is marked other than "natural; or herr any injury or other traumatic event, the Headless." Black, White, etc. XIXNever Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2000 Specify Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NAVY EXCHANGE SEAMTRESS 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 HELEN EADES EUGENE J. SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1400 MARLBORO RD. LOTHIAN, MD. 20711 SAMUEL E. SMITH (BROTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠Burial 2 ☐ Cremetion 3 ☐ Removel from State RESURRECTION CEMETERY 1/31/2000 CLINTON, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility
WM. REESE & SONS MORTUARY, P.A. 21. Signature of Funeral Service Licensee Larry Reese ST. ANNAPOLIS, MD. 21401 B21 WEST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Ateris desis of hidrey! GM Examiner Due to (or as a consequence of) Examiner ettending physician and for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 1 Yes 2 No 3 Probably ∮DUnknown Records, þ 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? certificate has 1 Yes 1 TYes 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours effect death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 8 Hospital: Other: Principle 5 Residence 6 Other (Specify) 10 1□ Yes 2⊟ No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? edical Certification: T Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of contries 29c. License number 29d. Date signed (Month, Day, Year) D32036 30. Name and address of passed who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 8 2000

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 1 1 5 2 8 5

| | | | | Certificate of | Death | Re | g. No. | 002.00 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------|--------------------------------------------|----------------------------------------|
| | 1. Decedent's Nama (First, Middla, La | st) | | | | 2. Data of Death Month | Day Year | 3. Tima of Death |
| Physician /Medical | Walter | T. Sit | tner | | | Jan. | 28, 2000 | |
| Examiner | 4a Facility Nama (If not Institution, give | a street and number) | | | 4b. City, Town, or L | ocation of Death | 4c. County of De | ath |
| | Genesis Eldercare- | · Spa Creek | | | Annapo | lis | Anne Aru | ındel |
| Funeral | 5. Social Security Number 6. S | Sex 7. Age (| In yrs. last birt | hday) If Under 1 Yea Months Days | | 8. Data of Birth (Month, Day, | Year) 9. Bi | irthplace (Stata or Foreign Country) |
| Director | 103-10-9853 | 1 X M 2□ F | 78 | rs. | Tiodis IVIII. | | | w York |
| 2 | Usual Rasidence of Decedent 10a. Steta 10b. County | | Oc. City, Town | | | | | |
| anyle anyle | 1 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | 10d. Inside City Limits 1 ☐ Yas 2 ☑ No |
| Ser Mark | Maryland Anne Ar | undel | | Annapolis | | | | Λ |
| vith the Mar or 28a-f a be notified Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of What C | Country? |
| ral la | 2000 Tundra Court | | | 21 | 1401 | | USA | |
| 5-0020 72 hours after death with the Manyland natural; or Items 23a or 28a-f ahow the Especial Paracter and by Funeral Director | 11. Marital Status | 12. Was Decedent Eve Armed Forces? | er in U,S. | 13. Was Decedent of If Yas, specify Cu | Hispanic Origin? (Sp ban, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - Arr Black, Wh | nerican Indian, iita, atc. |
| y F | 1 Never Married 2 Married | 1 XYas 2 No | | 1 ☐ Yes 2 ☑ No | o Specify: | | Specify: | |
| 21215-0020 d within 72 hours at glene. or than "natural", or then "natural", or then "completed by F | 3 Widowed 4 □ Divorced | | W II | A | | | | White |
| 1 21215-0 ed within 72 ho ygiene. Ar then meturi At, the Medical Completed | 15. Decedent'a En (Specify only highest gra | | 16a. | Decedent's Usual Occi (Giva kind of work don lifa. DO NOT use retir | upation e during most of work | cing 1 | l6b. Kind of Busines | s/Industry |
| within she. | Elementary/Secondary (0-12) | College (1-4or 5+) | | | eo) Engineer | | II C C | |
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| yland ylend build be file. Mental Hygerked otheratic avent, | Henry Sittner | | | | | | and on Tomamay | |
| aryla should marke marke To | 19a. Informant's Name/Relationship (| Time (Brief) | 100 | Mailing Address (Char | Hattie (| | City as Town Class | Zin Codel |
| € 4°2° | Henry P. Sittner | | | Mailing Address (Stree 39 Pindell | | | | 20 759 |
| CENL | 20a. Method of Disposition | | | Disposition (Nama of | SCHOOL KO | | 20c. Location - City of | |
| S 5 5 5 0 | 1 Burial 2 □ Cramation 3 □ | Removal from Stata | cematar | r, crematory or other pl | | | | |
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| Baltii Pemit. F Departm Importar Importar Importar Importar | 21. Signature of Funeral Service Licer | () 01 | | 22. Nama and Add | . 0. | | lor Funeral | |
| | C. Suai | fourt | | | of Glouceste | | | Md. 21401 |
| | 23a. Part1. Enter the disease, or com shock, or heart feilure. List only | plications that caused the one cause on each line. | a daath. Do n | ot entar tha moda of dy | ying, such as cerdiac | or respiratory arre | ost, | Approximata Intarval Between |
| Physician | West March 1997 and 1997 | 0 | 0.4 | 0 (| | - ^ | | Onset and Death |
| /Medical Examiner | Immediata Causa (Final diseasa or condition rasulting in death) | · KESY | OCRA | TORY | FAIL | RE | | DAYS |
| | rasulary at obality | A A A Du | e to (or as a c | onsequence of): | | lono. | | 1 |
| D 4 F | | 6. BRAU | N-C | JEH N | FOICE | 1010 | | 1 |
| death certificate be executed estimated by the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont | Sequentially list conditiona, if any, leading to immediate | Du | e to (or as a c | onsequence of): | 11.210 | THE ! | NAI ST | 13/10 |
| ficate be ey physician is the burle | Sequentially list conditiona, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury | c. cestle | 00 | 14/21-1 | VILLE | gik / | AIRA | 0/20 |
| phys the | that initiated events rasulting in death) Last | Due | e to (or es a c | onsequence of): | | | | |
| . = 9 | | d | | | | | | 1 |
| BOX seth cer attendin for use | | | | | | | | |
| | Pert II. Other significant conditions of | ontributing to death but n | ot resulting in | the underlying ceuse of | given in Part I. | | | te to the cause of death? |
| P.O. that the detach detach | HYPENGENSO | 00 / | ropes | C Voya | 15 (D) | 1 Ye | s 2□No 3□ | Probably A Unknown |
| The law requires to the law requires to has been significant because 2 should be completed by | C400000 | 100 | NA | e Ac | or about | 24a. Was ar | autoney 24b | o. Ware autopsy findings |
| The law require ale has been signed 2 should | CERTIFIE | - A/100 | >HCC | , Uzr | (20/4 | perform | | available prior to completion of cause |
| has law | | | |) | | | | of death? |
| = F aa o | | | | | | 1 ☐ Ya | 5 2 No | 1 Yas 2 No |
| yelclen: The law yelclen: The law director, page 2. | 25. Was case retarred to medical axaminer? | 4.5 | | | | th (Check only one | | |
| 0 5 5 8 | 1 Yas 2N No | Hospital: | 2 ER/Out | patient 3LI DOA | | | nce 6 Othar (Sp | pecify) |
| ng P ther unen | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Y | 9ar) 28b. T | ijury W | | 28d. Describe ho | w injury occurred | |
| SIC Seath leath too: / the f | 2 Accident Invastigation 3 Suicide 6 Could not b | | | | ☐ Yes 2 ☐ No | | | |
| DIVISION of tall or Attending Pres after death. al Director: After tiled in by the funeral Certification: | 4 Homicide determined | | - At homa, far Specify) | m, street, factory, office | е | 28t. Location (Str City or Town | | Rural Routa Number, |
| DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7 | 00-0-00- | * | | | | | | |
| ne Hospi n 24 hou ne Funer pletely fill edical | 29e. Certifier Contifying Ph | ysician: To the best of miner: On the basis of ex | aminetion and | death occurred at the Vor invastigation, in my | tima, date and place, opinion, death occur | and due to the ca red at the time, da | iuse(s) and manner ata and place, and d | as stated. ua to tha cause(s) |
| thin 2 thin 2 mple | 29b. Signature and title of certifier | and manner stated | 1. | 20c tion | nse number | 20 | 9d. Data signed (Mo | oth Dev Yearl |
| TATES - | 11/11/ | - 2-11h | 1 | 250.2108 | 3162 | | S. Duta agrico (MO | 1 |
| | Jugen | - WE | / | 07 | 10142 | | 1/201 | 00 |
| | 30 Nama and addrass of person who | | | | | | | |
| | S. David Krimins, | | | e Suite 301 | Annapolis, 1 | 4d. 21401 | | |
| State Registrar | FEB 0. Year 200 | 32 Registrar's | Signatura | I done | 11 | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Etta Irene Scible 30 2000 3:30 PM January /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Arundel Anne 8. Date of Birth (Month, Day, Year) Aug. 10,1917 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2X)F Months 214-05-0116 82 Director Maryland Usual Rasidence of Decedent the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notined at MD 1 ☐ Yas 2 No Director Anne Arundel Annapolis 10e Street and Number 10f Zin Code 10g, Citizen of What Country? Apt. 308 130 Hearne Rd. 21401 USA Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S.
Armed Forcas?
1 Yas 2 No
K Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours after toppertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Exercis 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 XWidowed 4 ☐ Divorced Yaar or Datas White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own home 17 Father's Nama (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Preston Leitch 0 Edith Kirby 19a. Informant'a Name/Ralationship (Type, Pnnt) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 285 Red Cloud Rd. Lusby, MD. 20657 Richard C. Scible / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 2-3-00 Annapolis, MD. 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funaral Sarvice Licens 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Entar tha diseasa, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner many Examiner attending physician and for use as the burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ The law requires 24b. Wera autopsy tindings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? peeu has 1 Yes 2 No certificata 25. Was case retarred to medical examiner? Be 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To Impatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physiwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 XNatural 1 TYes 2 □ No 2 Accident 6 Could not be datermined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29b. Signatury and Itla of certifier 29d. Data signed (Month, Day, Year) 0481 00 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Donna Chambers

DHMH 16 Ray 6/95

State

Registrar

31. Data tiled (Month, Day, Year)

FEB 0 1

32. Registrar's Signature

FEB 0 1 2000 Name - B. Sand

| | | Decedent's Neme (First, | Middle ! | est) | | | Certificat | e ot | Death | 2. Dete of De | Reg. No. | | 3. Time of Dea |
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| Exami | | 4a. Facility Name (If not ins | | | | | | | 4b. City, Town, or Lo | cation of Death | 4c. Count | y of Death | |
| | | Anne Arund | | | | | | | Annapolis | | | Arund | |
| Funerai Director | | 5. Social Security Number 213–28–6431 | | Sax 1□M 2∏ F | 7. Age (/ | n yrs. lest birti | frs. If Undar Months | Deys | ff Under 24 Hrs. Hours Min. | 8. Dete of Bin (Month, Da Oct 8 | th y, Year) , 1911 | 9. Births Cour Rhod | piece (Stete or Fo ntry) le Island |
| deeth with the Maryland rns 23a or 28a-f show Frust be notified at | _ | Usuai Residence of Deced 10a. Stete 10b. 0 | | | 10 | Oc. City, Town | or Location | | | | | 1 | 10d. inside City Li |
| Ne W | Sch | | ne Aru | ndel. | | Annapo | | | | | | | 1 ☐ Yas 2 Ŋ |
| ith the | Die | 10e. Street and Number | | | | | 10f. Zip | | | | 10g. Citizen of | What Coul | ntry? |
| a 23a o | eral | 38 Boxwood | Road | 40 Wes Des | andont Fire | n in 110 | 40 Was Daniel | 2140 | | -14 - 34 44 - | USA | ce - Amaric | and to dian |
| or its | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Div | | 12. Was Dec Armed F 1 Yes If Yes, G Yeer or I | orcas? 20 No | ir in U,S. | if Yas, spec | | dispanic Origin? (Spe en, Mexican, Puarto I Specify: | Rican, atc.) | Bie | ock, White, | |
| n 72 hours natural', soical Ex | Pe | 15. De | cedent's E | ducation | | 16a. | Decedent's Usue | ol Occup | petion | | 16b. Kind of B | | |
| Nen ' | Completed | (Specify only Elemantary/Secondary (i | | college (| (1-4or 5+) | | (Give kind of wor life. DO NOT us Meat | rk done se retire | during most of workii d) | ng | | ocer | , |
| Hygin Hygin | O | 17. Father's Name (First, N | liddle, Last |) | | | 1 Eac | wraj | 18. Mother's Name | (First, Middle, | | | |
| 2 should be filed vend Mental Hygie Is marked other transmitters of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results of the results o | To Be | Joseph | Archan | bault | | | | | Dela Ga | ene | | | |
| shou and M umat | - | 19a. informent's Neme/Ra | | | | 19b. | Mailing Addrass | (Street | end Number or Rure | | er, City or Town | , State, Zip | Code) |
| alth er 27 la er trau | | Deanna Jo | nes / | Daughter | | | 1639 Isab | ella | Ct. Millers | ville, M | 1. 21108 | | |
| permit. Pages 1 end 2 Department of Health Important: If item 27 is any injury or other tra since. | | 20e. Method of Disposition 1 ☐ Buriei 2 ☐ Crem 4 ☐ Donetion 5 ☐ Ot | | | | cameter | Disposition (Namer, cremetory or or or or or or or or or or or or or | ther ple | | Dete | 20c. Location Annapoli | | |
| ortar Inju | | | | | l. | THITCI | 22. Name an | | | | ylor Fune | - | Y |
| E SE S | 21. Signature of Funeral Service Licensee | | | | | | 1/7 D | .1 | | | | | |
| | | 23a. Pert1. Enter the disea shock, or heart feilure | se, or com | plicetions thet | caused the | death. Do n | | | of Glouceste: ng, such as cardiec o | | | is, m | Approximeta Interval Between |
| hysician /Medical | | immediata Cause (Final | . List only | | | , | | | | | | | Onset and Deat |
| Examiner | | disease or condition resulting in death) | | a.) | Du | e to (or as a c | onsequance of): | | | | | | 9 |
| 2 % | iner | | 4 | 2 (| SAN | GRENE | | | | | | | 100045 |
| cate be executed physician and the burial-transit | Examiner | Sequantially list conditions if eny, leeding to immediat cause. Enter Underlying Cause (Diseasa or injury | F. | 2 | Dha | a to (or as a c | onsequence of): | OM | Bosis 1 | NITH | | | 100445 |
| icate be executively by physician and the burial-trains | edicai | Cause (Diseasa or injury thet initietad evants resulting in daeth) Last | 1 | () | Due | to (or es e co | onsequenca of): | HV | POLOGAO | JABLE | STATE | 2 | |
| E 0 a | | | • | d | | | | | | | | | |
| o ette | icla | Part ii. Other significant co | nditlone | contributing to d | doath but n | at resulting in | the underlying or | nuso ai | on in Port i | 23h Did | tohacco usa cr | antribute t | o the cause of de |
| | / Physiclan/M | 10VA | nonona c | onthibuting to o | Joan Duti | ot resulting in | the underlying o | zuse gn | yon at Poit i. | | Yes 2 No | 3 □ Pro | 10 |
| iaw requires that the as been signed by the 2 should be detache | Completed by | 1 Hm | | | | | | | | 24a. Was | an autopsy med? | av | ere autopsy findir relieble prior to empietion of cause death? |
| certificate has | S | | | | | | | | | 10 | Yes 2 No | 11 | □Yas 2No |
| ertific ctor, | Be | 25. Was case referred to maxaminer? | edicai | | | | | | 28. Place of Death | (Check only o | one) | | |
| this certific | 2 | 1 ☐ Yes 200 No | | Hospitei: | Inpatient | 2□ ER/Out | | | 4 LI Nursing Hor | | | | fy) |
| After t | Certification: | | ending | | of injury nth, Dey Yo | 28b. Ti | ma of 2 jury M | 8c. Injui | | 28d. Dascribe I | now injury occu | rred | |
| or death. octor: Afte by the fune | cat | 3 Suicide 6 □ 0 | ouid not b | e one Dies | a of ini | At home for | | | Yas 2□No | ORF Location / | Street and Num | her or Dun | al Route Number. |
| after Direct | ertit | 4 ☐ Homicide | latarmined | build | ding, etc. (S | Specify) | m, street, factory | , onice | - | City or To | | Joi of FIGH | |
| within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | edical C | 29a. Certifiar 1X Ce (Check only one) | rtifying Ph dical Exar | niner: On the b | a best of mo | aminetion end | daath occurred a | at tha ti | ma, data and piace, a opinion, daeth occurre | and dua to the ed et the time, | causa(s) and m | annar as s | stated. o the ceusa(s) |
| ithin o the | Me | 29b. Signature and title of g | ertifieg | and mar | or stated | • | 29c | . Licans | sa number | | 29d. Dete signi | ed (Month, | Day, Year) |
| - s ⊢ ő | | 1 Horse | als! | N | | | | D3 | 25259 | | 1/3 | 0/00 | D |
| | | 30 Name and address of p | | complated cau | | (itam 23a) (1 | Seco V | ere | seans the | study | Miuses | WILL | NO 21108 |
| Sta | ate | 31. Data filed (Month, Dey, | Year) | 32. F | Registrar's | Signeture | 4 1 | - | 1 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 21108 |

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| | atherine Sherwo | State | of Maryland | | rtificate o | | | | g. No. | 10 | 052 | 8.8 | |
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| Physician | Decedent's Name (First, Mid Elizabeth Cat | | erwood | | Щ | | | Data of Death Month INUARY | Day | Year 2000 | 3. Time o | | |
| /Medical Examiner | 4a Facility Name (If not institut | ion, give street and nu | ımber) | | | 4b. City, To | own, or Location | | _ | y of Death | | | |
| | | Arundel H | dia . | | | | en Burn | | | e Aru | | | |
| Funeral Director | 5. Social Security Number 216–30–8034 | 6. Sex 1 ☐ M 2 ☐ F | 7. Aga (In yrs. le | ast birthday) Yrs. | If Under 1 Ya Months Day | | | Dala of Birth Month, Day, pr 4, | Year) 1934 | | piace (Stata intry) yland | or Foreign | |
| Maryland of show find at tor | Usuat Residence of Decedent 10a. State 10b. Coun MD Ann | e Arundel | | , Town or Lo | | | | | | | 10d. Inside C | City Limits | |
| th with the Mar the or 28a-f si at be notified al Director | 10e. Street and Number 606 Kensingto | n Avenue | | | 10f. Zip Code | 146 | | | og. Citizen of | What Cou | intry? | | |
| urs after death of the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standard from the standar | 11. Marital Status 1 Never Married 2 Nover 3 Widowed 4 Divorce | Armed Francisco | 2K) No iva | | Was Decedent of f Yes, specify C 1 ☐ Yes 2 ☐ M | | | Yes or No- in, atc.) | | ack, Whita | ican Indian, , atc. | | |
| 72 ho matur dical | 15. Decede | ent's Education lest grade complated) |) | 16a. Dece | dent's Usual Occ kind of work do DO NOT usa ret | cupation na during mos | at of working | 1 | 16b. Kind of 1 | Businass/le | ndustry | | |
| of 2 should be liked within 72 hours at th and Merkal Hygene. 7 is marked other than "natural", or traumetic event, the Medical Exam To Be Completed by I | Elementery/Secondary (0-12 | | State Government | | | | | | | | | | |
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| | John Sherwood/ husband 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 606 Kensington Avenue, Severna Park, MD 20b. Plece of Disposition (Name of cematary, crametory or other plece) Metro Crematory 108 Kensington Avenue, Severna Park, MD 20c. Location City or cematary, crametory or other plece) Jan 31 Baltimore | | | | | | | | | | | 0 | |
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| te be executed sysician and he burial-transit | Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Causa (Disease or Injury | 5 6. | b | | | | | | | | | | |
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| ysician: Thy director, pag | 25. Was casa referred to medic examiner? | Hospital: | 4-97 | | | Other | a of Death (C | | | | | | |
| 4 4 4 | 1 X Yas 2 No 27. Manner of Death | 10 | | ER/Outpatier 28b. Tima o | II 3LI DOA | 4UN | ursing Homa 28d | 5 Li Rasida Dascribe ho | | | eiry) | | |
| eath. or: After the fune | 1 □ Netural 5 □ Pend 2 ■ Accident invas 3 □ Suicide 6 □ Coul | d not be 286. Plec | of Injury nth, Dily Year) e of Injury - At hol ling, atc. (Specify, | me, ferm, str | SAM | njury al Work? Yes 242 | No Pe | J. f. | ian 5 f | ruet | by mr | mber, | |
| septal or Att hours after of ineral Directly filled in by | 29a. Cartifier 1□ Certify | ing Physician: To the | ree T | Ben | teld E | Olvot Ke | nsinger la | Jeve | erna | ra | clased | la- | |

State Registrar

proved causa of death (flem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29c. Licansa number

O.C.M.E.

29d. Data signed (Month, Day, Year)

January 29, 2000

FEB 0 2 2000 James D. Jane La

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Date of Death 3. Time of Death Month January 22,2000 1:40 P.M. William A. Sorrell 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days NOXM 2□ F Yrs. 80 April 26,1919 Washington, DC 579-14-0438 Usuai Rasidanca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas XX No Bladensburg Maryland | Prince Georges 10f. Zlp Code 10g. Citizen of What Country? 10e. Street and Number 20710 U.S.A. 5423 Spring Road 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yas 2 No If Yes, Give Year or Detas: 1 Navar Married Married 1 ☐ Yas 2 ▼ No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Coilege (1-4or 5+) Sunshine Biscuit Co. Salesman 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Mary Allen James Abraham Sorrel1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 4116 54th Place, Bladensburg, MD 20710 Golena M. Thompson/Executrix 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20s. Method of Disposition 1 Burial 2 Cramation 3 Removal from State Lincoln Cemetery January 26,2000 Brentwood, MD 20722 4 Donation 5 Other (Specify) 22. Name and Address of FacilityFt. Lincoln Funeral Home Signature of Funeral Service Ligenses 3401 Bladensburg Rd. Brentwood, MD 20722 albarel eese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth PANCREATITIS HCUTE Immediate Cause (Final disaase or condition resulting in death) ARTERY DISEASE Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury CONGESTIVE HEART FALLURE that initiated events resulting in death) Last OBSTRUCTIVE DULMONARY DISFASE 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check on y one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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/Medical

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Pages Department of I Important: If Ite

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The law requires that the death certificate be axecuted or Attending Physician: eftar deeth. After thi funeral Director: /

Division of Vital Records, P.

n 24 hours. the Funeral Direction Hospital edicai To the I within 2 To the I

Registrar

Certification:

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

28c. Injury at Work?

1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated.

1 Yes 2 No

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year)

28f. Location (Streef and Number or Rural Roufa Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. SINGH 1259 A HAND VER H AND VER PARKWAY GREENBELT MD 20770

28d. Describe how injury occurred

31. Date filed (Month, Day, Year) FEB 0 2 2000

5 Pending

invastigation

6 Could not be

27. Manner of Death

1 Netural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

32 Registrar's Signature

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| State of Maryland | Department of Health | and Mental | Hygiene |

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death M1721/2000 **Physician** SHEREE M SMITH 11.50PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 42 Yrs. Director 578 78 9115 WASH DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or herns 23a or 28a-f show the Wedical Example; must be notified at 1 Tres 2 No Directo WASH DC DC WASH_DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 611 EDGEWOOD TERR. NE 20017 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status hours efter 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: BLACK Baltimore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DRY CLEANING CLERK PRIVATE permit. Pages 1 end 2 should be filed v
Department of Health and Mentel Hygie.
Important: If item 27 is marked other ti
any Injury or other traumatic event, the 12 other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN R LUNSFORD CARRIE A PHILSON 19a. informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) $611\ EDGEWOOD\ TERR.NE\ WASH\ DC\ 20017$ SHARON SMITH DAUGHTER 20b. Place of Disposition (Nama of 20a. Method of Disposition Date 20c. Location - City or Town, State cematary, crematory or other plece)
HARMONY 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 1/28/2000 LANDOVER MD 21. Signati ure of Funeral Service. 22. Name and Address of Fecility POPE FUNERAL HOME 2617 PENN AVE, SE. WASH DC M/ OFS an 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical immediate Cause (Final END-STAGE RENAL disease or condition resulting in death) DISEASE ~ 2 hrs Examiner Dua to (or as a consequence of): Examiner DIABETES MELLITUS physicien and s the burief-transit be executed Sequentially list conditions, if any, leading to immediate ceuse. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760, SEVERE PULMONARY HYPORTONSION Physician/Medical Due to (or as a consequence of): for use es 80 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 1 Yes 2 No 3 Probably 4 Unknown be del Division of VItal Records. à 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 210 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s efter death. Il Director: After this certificat ed in by the funeral director, p 25. Was casa ratarred to medicel axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Plece of injury - At homa, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours eft To the Funeral Di completely filled in Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M. S. Wayer D-17874 1-28-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. M. NAYAR MD 3717-38 AVE COTTAGE CITY, MD 20722 31. Dete flied (Month, Dey, Year) FEB 0 1 2000 Pegistrar's Signature Registrar

Day & march 0005:000

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 0529

| | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death | | | | | | | | | | | | | | |
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| /Medical | TO E. W. M. E. W. C. C. C. W. A. | | C. Sw | antner | r | | Januar | | | 3:00PM | | | | | |
| xaminer | 4e Facility Name (If not institution, give | street and number) | | | | | r Location of Deat | | | 2010 | | | | | |
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| to de | Maryland Prince G | eorge's | Oxon I | Hill | | | | 1 ☐ Yea 🐴 ☐ | | | | | | | |
| be notified Director | 10e. Street and Number | | | 10 | Of. Zip Code | | | 10g. Citizen of V | What Countr | y? | | | | | |
| a le | 1821 Knoll Dr. | | | | 20745 | 5 | | US. | A | | | | | | |
| Funeral | 11. Marital Status | 12. Was Decedent Ev Armed Forces? | ver in U,S. | 13. Was I | Decedent of s. specify Cut | Hispanic Origin? | (Specify Yes or No erto Rican, etc.) | - 14. Rac | a - America k, White, et | | | | | | |
| b y | 1 ☐ Never Married 2 ☑ Merried 3 ☐ Wildowed 4 ☐ Divorced | 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: |) | | Yes 2 No | | | | Whit | | | | | | |
| r, the trades of Completed | 15. Decedent's Ed (Specify only highest grad | | 16a | Decedent's | s Usual Occu | pation | rorkina | 16b. Kind of Bu | usiness/Indu | istry | | | | | |
| ald w | Elementary/Secondary (0-12) | College (1-4or 5+) |) | | vor use retire | during most of w | OTHERS . | At Ho | m Q | | | | | | |
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| Spartment of Health and Mental moortants if fem 27 is marked only Injury or other traumatic evance. To Ba | John Boets | | | | | Jacka | | entjes | | | | | | | |
| | 19a. Informant's Name/Relationship (7 | | 198 | | ddress <i>(Stree</i> e as it | | Rural Route Numb | er, City or Town, | State, Zip C | code) | | | | | |
| the contract of | Phillip Swantner/ | nuspand | 20b. Place 0 | | | Lem 10 | Date | 20c. Location - | City or Tow | n State | | | | | |
| 6 | 1 ☐ Burial 2 ☐ Cremation 3 ☐ | | cemete | ry, cremator | ry or other pla | | | | | | | | | | |
| yani | 4 □ Donation 5 □ Other (Specify | | Metro | - | | | 2/1/2000 | Alexan | dria, | /A. | | | | | |
| any injury or phos. | 21. Signature of Funeral Service Licent | 9/ | | Geor Geor | me and Addr | Kalas F | uneral Ho | ome, P.A | | | | | | | |
| | 12-1-190 | als A | 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | | | | | | | | | |
| ician dical | 23a Part Enter the disease, or companded, or heart failure. Last only of immediate Cause (Finat disease or condition | V | | not enter the | e mode of dy | ing, such as cerd | ac or respiratory a | mest. | 1 1 | Approximate ntervat Between | | | | | |
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| Marry Gwendolyn Proctor/Sister 6601 Clinton Manor Dr., Clinton, MD 20735 | | James Marshall Proctor | | Elizabet | th | Ollie | | | |
| 20b. Please of Disposition 1 R Burstle 2 Circention 3 Removel from Stete 4 Doneting 5 Other (Specify) 21. Signstume/Frumerst Sprake Licenspan 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 0xon Hill Rd., 0xon Hill, MD 20745 23a. Part Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, infavorable and infavorable for constituting in death of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate infavorable and cause (Final disease or condition) a Arteriosclerotic Heart Disease Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): 25. Was case referred to medical exembre. The conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical exembre. Duals to (or as a consequence of): 26. Pleas of Death (Check only one) 27. Were autopsy valiable port of death of the cause of the performed? 28. Was case referred to medical exembre. The performed? 29. Was case referred to medical exembre. The performed? 20. Calcident of the performed? 20. Calcident of the performed? 20. Death (Check only one) 22. Was case referred to medical exembre. The performed? 22. Was case referred to medical exembre. The performed? 22. Was case referred to medical exembre. The performed? 22. Was case referred to medical exembre. The performed? 22. Was case referred to medical exembre. The performed? 22. Was case referred to medical exembre. The performed? 22. Was case referred to medical exembre. The performed? 22. Was case referred to medical exembre. The performed? 22. West an autopsy exhibition of death (Check only one) 22. Was case referred to medical exembre. The performed? 22. West and the performed? 22. West and the performed? 22. West and the performed? 22. Death of Injury March | | e. Informent's Name/Ralationship (Type, Print) 19b. N | Mailing Address (Street | et and Number or Run | al Route Number, | , City or Town, | State, Zip | Code) | |
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| A Donoteion S Other (Specify) Resurrection Cemetery 2/2/2000 Clinton, Maryland 22. Neme and Address of Facility George P. Kalas Funeral Home, P. A. 6160 0xon Hill Rd., Oxon Hill, MD 20745 | | comotony | Disposition (Name of cremetory or other p | lece) | Date | 20c. Location - | City or To | wn, Stata | |
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| 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 1/28/2000 | atic | 2 Accident investigation | | | | | | | |
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| 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/28/2000 | 5 | | | | | | | | |
| 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/28/2000 | dical | (Check only 2 Medicat Examiner: On the basic of examination and/o | deeth occurred at the or investigation, in my | time, dete end place, r opinion, daath occurr | and due to tha ca red at the time, da | cause(s) and menner as stated. date and placa, and due to the ceuse(s) | | | 9(s) |
| | | b. Signeture and title of certifier | 29c. Lice | nse number | 25 | 9d. Date signed | d (Month, | Day, Year |) |
| | | 5 | D1 290 | 06 | 1 | /28/200 | 00 | | |
| I WI Name and address III through who completed cause of death (from 30-1) (Time Deint) | - | Name and address of the record up a completed course of death (flow co.) C | | | | , _ 3, _ 00 | | | |
| 30. Name and address of a roon who completed cause of death (them 23a) (Type, Print) Louis Kaufman, M.D. 8926 Woodyard Rd.#602, Clinton, MD 20735 | | | | linton MD | 20735 | | | | |
| Louis Rauman, M.D. 8920 Woodyard Rd. #002, Cliffcon, MD 20733 31. Date filed (Month, Dey, Year) FEB 0 1 2000 32. Registrer's Signeture | | Date filed (Month Day Year) 20 Begintrede Cindeburg | - | - Incom, in | 20100 | | | | |

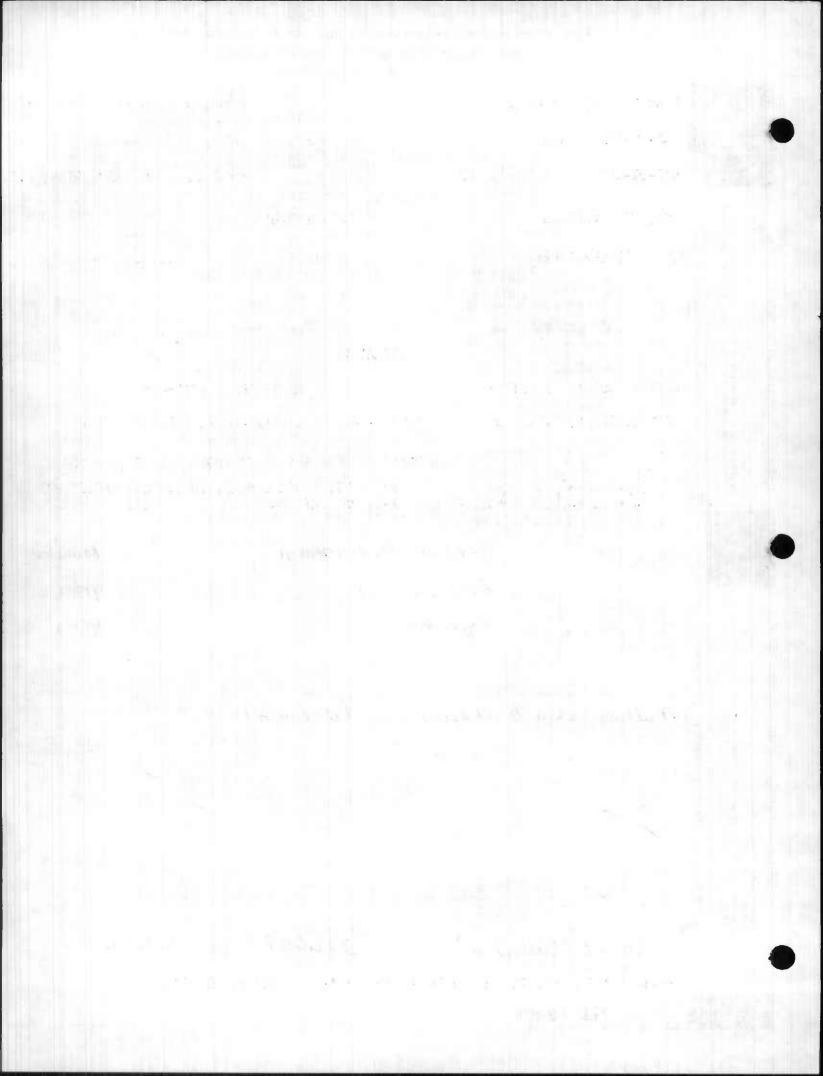
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| State of Maryland | / Department | of Health and Mental | Hygiene |
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| m. data | 1. Decedent's Name (First, Middla, L. | | | | | 2. Date of Death Month | Day | 3. Time of Death | | | |
| Physician - /Medical | BESSIE MARIE T | HOMAS | | | | FEBRUARY | 7, 200 | 8:30 AM | | | |
| Examiner | 4a Facility Name (If not Institution, gi 2889 CHIPPEWA ST | 4c. County o | ARLES | | | | | | | | |
| Funeral Director | 577-01-3677 | Sex 1□M 2♥F 7. Age (In y | rs. last birthday Yrs. | Months Day | | | | Birthplace (Stata or Foreig Country) WASHINGTON, D | | | |
| f ahow led at | Usual Residence of Decedent 10a. State 10b. County MARYLAND CHARLE | | City, Town or L | | ANS ROAD | | | 10d. Inside City Limits 1 ☐ Yes 2 🕅 No | | | |
| than "naturel", or items 23s or 28s-f show be Medical Examiner must be notified at ompleted by Funeral Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of W | hat Country? | | | |
| 23a c | 2889 CHIPPEWA STR | _ | | | 20616 | | U.S.A. | | | | |
| of, or tiems 23a or 28a-f show Examiner must be notified at by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yas, Give Year or Dates: | 1 U,S. 13. | Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N | | Specify Yes or No- rto Rican, etc.) | | - American Indian, c, White, etc. WHITE | | | |
| Hygiena. ther than "naturel", of the Medical Examination of the Medical Examination of the Medical Examination of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical of the Medical | 15. Decedent a E (Specify only highest gi Elementary/Secondary (0-12) | ducation ada com <i>plated)</i> College (1-4or 5+) | (Giv. | dent's Usual Occupation a kind of work dona during most of a DO NOT use ratired) CRETARY | | orking | DIRECT | MAIL | | | |
| 555 | 17. Father'a Name (First, Middla, Las | 1) | JL | OKLIAKI | 18. Mother's No | ame (First, Middla, M | 1 2 1 11 1 | a) | | | |
| umatic eve To Be | ROBERT MORGAN | SULLIVAN | | | ANNIE | MAE SKI | DMORE | | | | |
| lam 27 is marke other treumatic To | 19a, Informent's Name/Relationship | | | | | Rural Routa Number, | | | | | |
| itam 27 other t | MARY E. CRAWFORD 20a. Method of Disposition | | . Plece of Disp | osition (Nema of | | (ANDRIA, V | | A 22306 City or Town, State | | | |
| - | 1 X Burlat 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Speci | Removal from State | cematary, cri | amatory or other p | | | | | | | |
| important: if eny injury o phce. | 21. Signature of Funeral Service of the | nsee C | | TION CEM | Iress of Facility | | | N, MARYLAND | | | |
| JPK | × 1100 | un | 1 | HE HUNTT | FUNERAL | HOME, INC | ., POS | OFFICE BOX | | | |
| | 23a. Part1. Enter the disease, or cor ahock, or heart failure. List only | nplications that caused the de | eath. Do not e | nter the mode of d | ying, such es card | LAND 206 or respiratory arre- | U4-U15t | Approximate Interval Between | | | |
| cian lical | Immediate Cause (Final disease or condition | | | ARRHYT | | | | Minutes | | | |
| iner | resulting In death) | Due to | o (or as a conse | equence of): | | | | | | | |
| iel-transit Examiner | | U | ROSCER | | | | | years. | | | |
| s the buriel-transit edical Examir | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying | , / | o (or as a conse | | | | | years. | | | |
| edicai | Ceusa (Disease or Injury that initiated events resulting In deeth) Last | C | (or as a conse | | | | | 9641 | | | |
| E Z | | d | | | | | | | | | |
| for use | | | | | | | | | | | |
| be detached by Physic | Multiple ski | , | | | | | | tribute to the ceuse of deeti 3 Probably 4 Unknow | | | |
| ate has been signed by the ettend, page 2 should be detached for us. Completed by Physician/ | | | | | | 24e. Wes an perform | | 24b. Were autopsy findings aveilable prior to completion of cause of death? | | | |
| page Com | | | | | | 1 ☐ Yes | 2 1 No | 1 Yes 2 No | | | |
| rector, p | 25. Was case referred to medical examiner? | | | | | eath (Check only one | | | | | |
| F G | 1 Yes 2 No 27. Manner of Death | | ER/Outpation | | | Home 5 Resider | | | | | |
| After funer fon | 1 ■Netural 5 □ Pending | 28a, Date of Injury (Month, Day Year |) Zoo. Time Injury | V | /ork? ☐ Yes 2 ☐ No | 280. 0000100 1101 | w injury occurr | | | | |
| at Director: After tiled in by the funeral Certification: | 2 Accident investigation 3 Suicide 6 Could not determined | OB Disco of Injury A | t home, ferm, s ecify) | treet, factory, offic | ea | 28f. Location (Str. City or Town, | eet and Number Stele) | er or Rural Routa Number, | | | |
| To the Funeral Director completaly filled in by the Medical Certific | 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) 29e. Certiflar (Check only one) | | | | | | | | | | |
| To the comp | 29b. Signature and title of certifier | | | | ense number | | | (Month, Day, Year) | | | |
| | > Idward 1 (| ullen W | | DZ | 6607 | | FRKUAK | 7, 2000 | | | |
| | 30. Nema and eddress of person who | | | | LOU HETO | ITC ND O | 0740 | | | | |
| | EDWARD CULLEN, M | | | VE., MAR | LOW HEIGH | 115, MU 2 | 0748 | | | | |
| State | OT. Date med (Mornin, Day, 1881) | 32. Registrar's Si | Augunta. | | | | | | | | |

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| Type of the made made and made And opics Are Legi | |
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| State of Maryland / Department of Health and Mental Hygiene | 0529 |
| Cartificate of Death | |

| | | | | | Ce | rtificate | of D | eath | | | Reg. No. | | | |
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| Dhualaia | | Decedant's Nama (First, Middla, Last) | | | | | | 2 | Data of De | | Yaar | 3. Tir | na of Deeth | |
| Physicia: /Medica | | Lottie | Chaney | Tic | ce | | | | F | EBRUAF | RY 5 | 2000 | 8:2 | 5 AM |
| Examine | | 4a. Facility Nama (If not institution, g | giva street and numbe | ar) | | | 4b. | City, Town | n, or Loca | tion of Death | 4c. Cou | nty of Death | | |
| 2707777 | | St. Mary's Hosp | ital | | | | L | eona | rdtow | vn | St | . Mar | v's | |
| Funeral | | | · | | | | Yeer | If Under 24 | | | | 9. Birth | nlaca (S | ate or Forai |
| Director | | 219-50-9044 | 10 M 20 F 8 | 39 | Yrs. | Months [| Deys | Hours | Min. | Data of Birt (Month, Da June 2 | 6, 191 | O Ma | ry a | nd |
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| lanc ow | Ì | 10a. Stata 10b. County | | 10c. City, | , Town or Lo | ocation | | | | | | | 10d. fnsl | da City Lim |
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| 28s | Directo | 10e. Street and Numbar | nda | | | | | | | | | | | |
| T S S | ٥ | 1414 Cedar Lane | | | | 10f. Zip Co | 650 | | | | | Citizen of What Country? | | |
| s 23 | era | | 10 Was Daniel | nt Francis 11 C | 140 | | | | .0. (01) | | | | | |
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| nat Dist | ete | 15. Decedant's (Specify only highast g | Education grade complatad) | | 16a. Dece (Giva | dant's Usual C kind of work of DO NOT usa | Occupation dona dur | on ring most o | of working | | 16b. Kind of | Businass/i | ndustry | |
| peamit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23s or 23s-f show importants if item 27 is marked other than "natural", or items 23s or 23s-f show injury or other traumatic event, the Medical Existing and the confidence once. To Be Completed by Funeral Director | | Elamantary/Secondery (0-12) | College (1-4o | or 5+) | | | | | | | | | | |
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| DUE E | | 19a. Informent's Neme/Relationship | (Type, Print) | | 19b. Maili | ng Address (S | Straat and | d Number | o <i>r Rural F</i> | Route Numbe | er, City or Tov | vn, Stata, Z | ip Code) | |
| 27 tr | | Herbert Tice (| Son) | | P.0. | Box 3 | 25. | Avenu | ue. M | laryla | nd 206 | 09 | | |
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| eath certificate be executed attending physician and ifor use as the buriel-trensit | VMedical Examiner | Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Causa (Disaase or injury that initiated evants rasulting in deeth) Last | o. Cas | A . | es e consec S C C as a consec F i G as a consec | P | | des | ea | ne. | | | love | 15 |
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| v raquira been sig should t | | | | | | | | | | 24a. Was | an autopsy | 24b. V | Vara auto velleble p | psy finding |
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| ed in | building, etc. (Spacify) | | | | | | | | | | | | | |
| within 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral director. | edical | 29a. Cartifier (Check only one) 1 Certifying P | Physician: To the bes aminer: On the basis and manner | of axemination | rladge, death on and/or in | n occurred et t vestigetion, in | tha tima, my opin | data and i | placa, and occurred | dua to tha at tha tima, | ceusa(s) end data and plac | manner as e, and dua | steted. to tha ca | use(s) |
| within comp | Σ | 29b. Signatura and titla of certifier | A | | | 29c. L | icansa n | umber | | | 29d. Data sig | nad (Month | Day, Ya | ar) |
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| | - | 2)2 | | f double fla- | 00=1 (7: | | - 1 | 101 | 00 | | | | | |
| | | 30. Name and address of person who AVANI D. SHAH M. | | | | | | D | AT T | | | | | |
| | | | | LIP J. | BEAN . | MEDICA | L CT | R. HC |)LLYW | OOD, MI | D. 206; | 36 | | |
| State | | 31. Data filed (Month Ed. Year) | 2000 32. Radis | strar's Signati | ure 4 | 1 | uls | , | | | | | | |
| Registra | ı | - 0 1 | // | | / | Japo | -cres | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 05295

29d. Data signed (Month, Day, Year)

| | 1. | Decedent's Nan | ne (First, Middle | e, Last) | | | | - | | | | | 2. Date of D | | | | 3. Time o | f Death |
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| any injury pace. | 2 | 1. Signature of F | | pecify) | Garol | State | | ace C | emeter Nama an attin | y d Addres gley | ss of Facility - Gard | dine | /14/2000 r Funer | al Ho | me, | P.A | 0650 | |
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29c. Licansa number

parks

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

J. Patrick Jarboe, MD Hollywood, Maryland 20636

32. Registrar's Signature

Registrar

29b. Signature and title

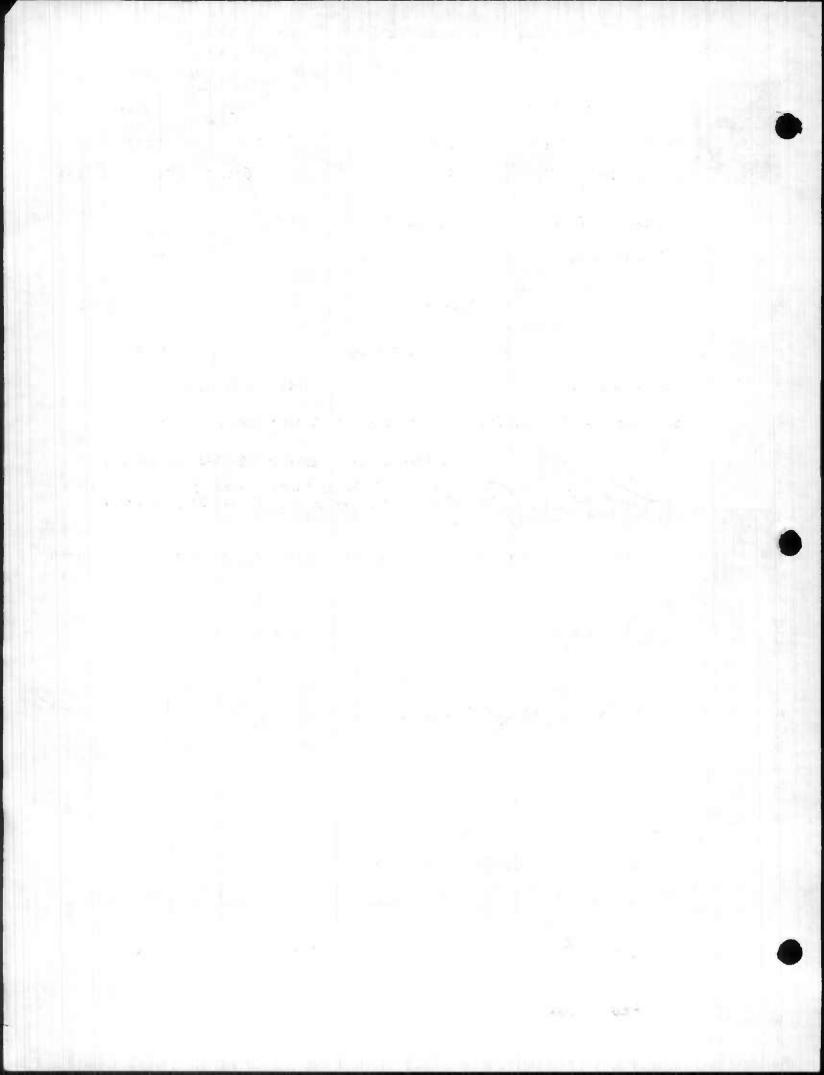
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Month Dev **Physician** John Littleton Thomas 10:00pm Feb 2 2000 /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun
If Under 24 Hrs. 8.1 Calvert Manor Healthcare Center Cecil 5. Social Security Number 6. Sax tX M 2□ F If Under 1 Year 8. Dete of Birth (Month, Day, Year) Oct. 5, 19 7. Age (In yrs. lest birthdey) Birthpiece (State or Foraign Country) **Funeral** Deys Hours Yrs. 222-03-1386 84 Maryland Director Usuel Residence of Decadent filed within 72 hours efter death with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov 1 Yes 2 No Director Maryland Cecil Risina Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 110 Arbor Lane 21911 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Give Yaar or Detes: 1948-68 items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 Ö 1 ☐ Yes 2 No Specify: 3 ☐ Widowad 4 ☐ Divorced natural', White 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest greda completed) Peges 1 and 2 should be filled within nent of Heelth and Mental Hygiene, nnt: If item 27 is marked other than 1 ary or other traumatic event, trail Mental traumatic event, trail Mental traumatic event, trail Mental traumatic event, trail Mental traumatic event, trail Mental traumatic event, trail Mental traumatic event, trail Mental traumatic event, trail Mental traumatic event, trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental trail Mental College (1-4or 5+) Elementery/Secondary (0-12) First Sergeant U. S. Army 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Surneme) John Edgar Thomas Clara A. Bloodsworth 19a. Informent's Neme/Ralationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Beatrice E.N. Thomas/Wife PO Box 374 Rising Sun, MD 21911 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Depertment of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) New London Pres. Cemetery2-5-2000 New London, PA 21. Signalate of Furniral Service Licensea 22. Name end Address of Facility R. T. Foard Funeral Home, P. A.
111 S. Queen St., Rising Sun, MD 21911

suped the aboth. Do not enter the mode of dying, such as cardiac or respiretory arrast, uchan 23a. Pert Enter the diseese, or complications to shoot or heert feilura. List only one cause Approximata Intarval Between Onset end Deeth Physician Pulmmary disease years" /Medical Immediate Ceusa (Final disease or condition resulting in death) Examiner Dua to (or es e consaquance of) Examiner Attending Physician: The law requires that the death certificate be executed and -tran Sequentially list conditions, if eny, laading to immediate cause. Enter Undarlying Ceusa (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequance of) P.O. Box 68760, physician Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causs of death? are nes been signed by page 2 should be detact 3 Probably 4 thinknown 1 Yes 2 No Division of Vital Records, p 24b. Ware autopsy findings available prior to completion of cause of daath? Completed 24e. Wes an autopsy performed? this certificate 1 Yas 2 → No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Piece of Deeth (Check only ona) Other: 4 Mursing Home 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Mannar of Deeth 28b. Tima of Certification: 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Maturel 5 Pending invastigation death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend efter death Director: illed in by the 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, ferm, streat, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled is Teartifying Physician: To the best of my knowledge, deeth occurred et the time, deta end plece, end due to the cause(s) and mennar as stated.

| Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, deta and place, and due to the cause(s) end manner stated. Medical 29a. Cartifier 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 344102 William F. Renzulli, M.D. DHVA 30. Name and eddrass of person who complated cause of deeth (Item 23e) (Type, Print) 901 Warburton Road 31. Dete filed (Month, Dey, Year) FEB 0 4 2000 Elkton, MD 21921 32. Registrar's Signeture State Registrar



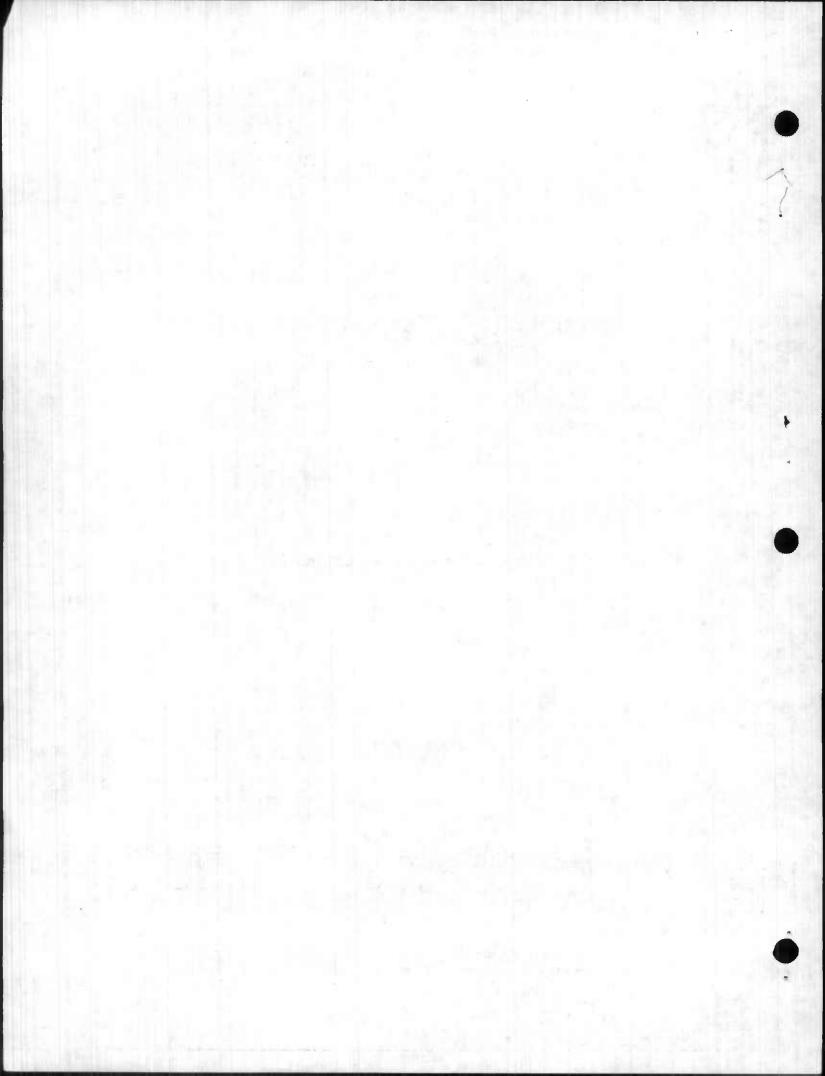
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| 1. Decedent's Nama (Firs | st, Middle, La | st) | | | | | 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day Ya | | | | | | | | | |
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| AHMAD | | TAMAL | TUT | WILER | | | | JANUAR | Y 31,2 | 2000 | 7:15 | | | | | |
| 4a Facility Name (If not in | | | | | | 4b. City, To | wn, or Lo | or Location of Deeth 4c. County of Death | | | | | | | | |
| 279 RED CLA | AY ROAI | | | | | LAUR | EL | | AN | E AF | RUNDEL | | | | | |
| 5. Social Sacurity Number | | Sax 7. | Age (In yrs. la: | Mo | Under 1 Yaar onths Deys | | 24 Hrs. Min. | 8. Data of Bir (Month, Da | th ay, Year) | 9. Bi | irthplaca (Stat Country) | | | | | |
| 329-66-10 | 62 | LES M SCI F | 27 | Yrs. | | | | Septe | | | | | | | | |
| Usuel Residence of Dece 10a. State 10b. | County | | 10c. City, Town or Location | | | | | | | | | | | | | |
| Maryland | Anne | Arundel | La | urel | | | | | | | 10d. Insida | | | | | |
| 10e. Street and Number | | | 10f. Zip Code | | | | | | 10g. Citizan of Wha | | | | | | | |
| | 010 | Dood | | | 2072 | Λ | | | U.S. | | | | | | | |
| 279 Red | Clay | 12. Was Decede | ent Evar in U,S | 5. 13. Was I | | | gin? (Spe | ecify Yas or No Rican, etc.) | | lace - Am | narican Indien, | | | | | |
| 1X Never Merried 2 | | Armed Force 1 ☐ Yas 2 1 Yas, Giva | | | s, specify Cub ∕as 2 іXNo | | , Puarto | Rican, etc.) | Spe | lleck, Wh | ile, atc. | | | | | |
| 3 ☐ Widowed 4 ☐ D | Divorced | Yeer or Data | is: | | | | | | | B | lack | | | | | |
| | Decedant's Ed ly highest gra | ducation ada complated) | | 16e. Decedant's (Giva kind | of work done OT usa retire | pation during most | of work | ing | 16b. Kind of | Busines | s/Industry | | | | | |
| Elementary/Secondary | (0-12) | Collega (1-4d | or 5+) | | | ed) | | | 0 | | 100 | | | | | |
| 17. Father's Nama (First, | Middle, Last |) | | Gu | ard | 18. Motha | r's Name | a (First, Middle | Secu: | | | | | | | |
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| Dianne | | | Mother | | 27 Ch | | | | exand: | | | | | | | |
| 20e. Method of Dispositio | | ,1101 | 20b. Pla | ace of Disposition | (Nama of | | | Data | | | or Town, Steta | | | | | |
| 1 ☐ Burial 2X Cra | mation 3 | | ata | matary, crametor | | | | -10-0 | 0 Da | 10 0 | City, | | | | | |
| 4 Donation 5 C | | | POL | omac C | | | | | | | | | | | | |
| > / | OUTVIOR EIGOT | 11 | - 1 | AD | ianif | ied I | Tune | ral & | Crema | atic | n Ser | | | | | |
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| Name of the second | aasa, or com ire. List only | | JUNSHO | 1 | 8401 a moda of dyl | Cedai | cardiac o | rive | Trian | | VA Approxim | | | | | |
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DHMH 16 Rav 6/95

Registrar



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| | Sta | te of Maryland / Department of Health and | Mental Hygiene | 05298 |
| | | Certificate of Death | Reg. No. | |
| 1. Decedent's Neme (F | First, Middle, Last) | | 2. Date of Death Month Day | 3. Time of De |
| Phyllis | L. | Turre11 | February 1, 20 | 000 6:30 / |

/Medical **Examiner**

Funeral

Physician

Director r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 72 hours after

Baltimore, Maryland 21215-0020

Department of Health and Mental Hygiene.
Important: If from 27 is marked other than "natural", or her any injury or other treumatic event, the Medical Examine pance.

Physician /Medical Examiner

Box 68760

Records, P.O.

Division of Vital

and physician a that the death certificate be Physician/Medical 82 signed t Completed page 2 certificate Be Medical Certification: To this To the Hospital or Attending Pi II in 24 hours after death. To the Funeral Director: After th completely filled in by the discoun-

Phyllis M 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Casey House Hospice Rockville Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1□M 2 F Months Hours 66 Yrs. 540 34 7241 1933 April 4, Oregon Usual Residence of Decedent 10a. Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Directo Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24824 Showbarn Circle 20872 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 🗓 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5+ Administrative Secretary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Sheeley Lois Engen 19b. Mailting Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 24824 Showbarn Circle, Damascus, MD Charles R. Turrell / Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Feb. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Chesapeake Crematory Inc. 2000 4 ☐ Donetion 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral-Service Licensee Rappo Felferal Failed Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 23a. Pert1. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finel diseese or condition resulting in deeth) Lymphangetic spread of breast cancer 1½ months Due to (or as a consequence of): Metastatic breast cancer 1+ years Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 € Unknown Hypercalcemia þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Pleural Effusion 1 Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 NOther (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 (XNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D35996 February 1, 2000 inde 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, M.D., 2101 Medical Park Dr. #210, Silver Spring, MD

State Registrar 31. Dete filed (Month, Day, Year,

FEB 0 4 2000

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Spork

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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| | Funeral | 5. Social Security Number | 4.0 | X M 2□ F | Age (In yrs. la: | | Months Day | | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, De | v Year) | 9. Birth | place (State or Foreign intry) thiopia | |
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| | vith the Me to 28e-f a be notified Director | 10e. Street and Number | | | | | 10f. Zip Code | 9 | | | | 10g. Citizen of | What Cou | intry? | |
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| | effer death with the Merylan or Nems 23s or 28s-f show union must be notified at / Funeral Director | 11. Maritel Status | | 12. Wes Deceder | nt Ever in U,S. | 13. V | Vas Decedent o | of His | panic Ori | gin? (Sp | ecity Yes or No | - 14. Re | | ican Indien, | |
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| 21215-0020 | by E. | 3 □ Widowed 4 □ Di | ivorced | If Yes, Give Year or Dates | S: | 1 | ☐ Yes 2XX N | ło | Specify: | | | Specia | y: | Black | |
| P | 172 hours effer death with the Maryland *natural*, or Items 23a or 28a-f show ledges Examiner must be notified at leted by Funeral Director | 15. De | ecedent'a Edu | cation | | 16a. Deced | ent's Usual Occ | cupet | ion | | | 16b. Kind of B | lusiness/îr | ndustry | |
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| an | See S | Tadesse | | | | | | | | | | Shewanda | | | |
| 3 | marked av | | | | | | | | | | 0 | | 0 | | |
| _ | 0 | 19a, Informent's Name/Re | | | _ | | | | | | | er, City or Town | | | |
| , | | | esse, | Brother | | 900 E | | - | ру. | # 13 | | field, N | | | |
| 2 | 2 7 2 0 | 20a. Method of Disposition 1☑ Burial 2 ☐ Crem | | Domousi from Stat | COL | ce of Dispor netery, cren | sition (Name of natory or other p | olace |) | į | Date | 20c. Location | | | |
| Ĕ | 8527 | 4 Donation 5 0 | | | nily | Cemeter | У | | ic | 2/10/0 |) Addis | s Abe | ba,Ethiopi | | |
| Baltimore, | 유물등등 | 21. Signatura of Funeral S | Service Licens | iee | | 22 | Name and Add | dress | of Facilit | v | - | | 1 | | |
| 0 | Ped Ped Ped Ped Ped Ped Ped Ped Ped Ped | 11/2 / | 1 | Baran | 10 2- | 1/101 | | , | | | | n Funera | | | |
| | | 22a Part 1 Enter the disc | C) / | Jucos | ccoj | 06/ 34 | 4/ 14t | h | Stre | et N | .W. Wa | ashingto | n,D. | C. 20010 | |
| | | 23a. Part1. Enter the dise shock, or heart feilur | e. List only o | ne cause on each | line. | DO NOT GUIL | of the mode of t | лунчу. | , auun aa | Cardiac | or respiretory e | rrest, | | Intervel Between Onset and Death | |
| | Physician | and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t | | | 1. | | 7. | | | | | | 1 | Crises and Deali | |
| | filledical Examiner | Immediate Cause (Finel disease or condition | | | Deizu | IRE | DISORI | DER | ? | | | | 1 | | |
| | | resulting in death) | | | | as a conseq | | | | | | | İ | PA FL | |
| - | - | | | | | | | | | | | | | | |
| | n certificate be assecuted and in graphysician end use as the burial-transit in/Medical Examiner | Sequentially list conditions | | b | Due to (or a | is a conseq | uence of): | | | | | | 1 | | |
| 2 | certificate be arecting physician enuse as the bunkl-tru. | Sequentially list conditions if any, leading to immedia cause. Enter Underlying | te | | | | | | | | | | | | |
| ox 68/60, | o point | Cause (Disease or injury that initiated events | | c | Due to (or a | F 9 CODE00 | reace off. | | | | | | - | | |
| 9 | A A | resulting in death) Last | | | Due to (or a | is a consequ | rence or). | | | | | | | | |
| × | ding & | | | d | | | | | | | | | | | |
| ă | | | -7 | | | | | | | | | | | | |
| 5. | signed by the str d be detached for d by Physicia | Part II. Other significant c | onditions co | ntributing to death | but not result | ing in the ur | derlying cause | giver | n in Part I | • | 23b. Did | tobacco use co | ontribute | to the cause of death? | |
| 1 | T to the | | | | | | | | | | 10 | Yes 2 No | 3 Pr | obably 4 Unknow | |
| o) | requires that seen signed is should be dete | | | - | | | | | | | | | 1 | | |
| 5 | The law requir | | | | | | | | | | | en eutopsy ormed? | 9 | Vere autopsy findings veilable prior to | |
| Hecords, | > | | | | | | | | | | | | 0 | ompletion of cause f death? | |
| Ĭ | The law its has bege 2 a | | | | | | | | | | 18 | Yes 2□No | 1 | Yes 2 No | |
| | iii jost | OF Was seen referred to a | nadical | | | | | | | | / | | 1 ' | 2010 | |
| VITAI | Physician: The this certificate ral director, per TO Be Co | 25. Was case referred to rexaminer? | P20-200 | Hospital: | 2.8 | | _ (| Other | - | | h (Check only | | | | |
| 5 | this of the To | No 2 Mo | | 1 ∐ Inpa | | P/Outpatien | 3LI DUA | | 4 LI NO | irsing Ho | | idence 8 Ot | | ity) | |
| DIVISION OF | Attending Physician: The law ar death ar and ar death are cotor; Alter this certificate has by the funeral director, page 2 iffication: To Be Comp | 27. Manper of Death | Pending | 28a. Dete of In (Month, E | Day Year) | 8b. Time of Injury | 28c. In | | | | 28d. Describe | how injury occu | rred | | |
| 000 | Attending in death. ector: After by the fune fune fune fune fune fune fune fun | 2 Constitution | investigation Could not be | | | | M 1 | ПА | es 2 🗌 | No | | | | | |
| Ē | or Attendant after death Director: | 3 ☐ Suicide 6 ☐ 4 ☐ Homicide | determined | | njury - At hometic. (Specify) | e, farm, str | et, factory, offic | 08 | | | | 'Street end Num wn, Stete) | ber or Ru | ral Route Number, | |
| 2 | tal or Attending P rs after death. al Director: After tel led in by the funer. Certification: | | | | | | | | | | | | | | |
| | | 29a. Certifier 1□ C | ertifying Phy | sician: To the bes | at of my knowle | edge, death | occurred at the | time | , date an | d place, | and due to the | cause(s) and m | annar as | stated. | |
| × | n 24 hound no 24 hound no Funer pletsly fill | (Check only 2 M | edical Exami | ner: On the basis and manner: | of examinatio steted. | n and/or inv | estigation, in m | y ope | nion, dee | th occur | red et the time, | date end place | and due | to the cause(s) | |
| | M of the | 29b. Signature and title of certifier 29c. License number | | | | | | | 29d. Date signed (Month, Da | | | , Day, Year) | | | |
| | ->-0 | | J. MY | 1. 11 | | | | 0. | C.M. | E. | | Fohmen | , 02 | 2000 | |
| - | (1) | 110111 | | | | | | | | | | Februar | y U3, | 2000 | |
| | 101 | 30. Name and address of p | erson who co | ompleted cause of | death (Item 2 | | | | | | | | 2.00 | 201 | |
| | | JACK | 1117 | rius Mi | D, | | Penn St | cre | et, | Balt | imore, | Maryla | nd 2] | .201 | |
| | State | 31. Date filed (Month, Day, | | 32. Regis | strar's Signatu | re | | | | | | | | | |
| | Registrar | FEB 0 | 4 ZUUU | Bro | man " | A | 1 | , | | | | | | | |

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Physician 27, AUDREY MAE TUCKER **JANUARY** 2000 12:50 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6703 97TH AVENUE T.ANHAM PRINCE GEORGES If Under 24 Hrs 8. Data of Birth (Month, Day, Y MAY 20, 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplaca (Stete or Foreign Year) 1926 Deys 10 M 20 F Min Months Hours WEST VIRGINIA 73 236-28-9923 Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 200 No Director MARYLAND PRINCE GEORGES LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20706 5TH STREET Funeral 9211 12. Wes Decedent Evar in U,S. Armed Forces? 1 1 Yes 2 1 No If Yes, Giva Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Status Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: P 3 Nidowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18 Mother's Neme (First Middle Meiden Sumame) 17. Father's Name (First, Middle, Last) 8 UNOBTAINABLE ROSALIE GREER 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) TUCKER 9124 FOWLER LANE, LANHAM MARYLAND 20706 DALE 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 1 - 29 - 00FORT LINCOLN CEMETERY BRENTWOOD, MARYLAND 4 Donation 5 Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name end Address of Fecility
FORT LINCOLN FUNERAL HOME INC.
3401BLADENSBURG RD, BRENTWOOD MD 20722 Jalung M00907 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death CONGESTIVE CARDIOAPATHY Immediate Cause (Finel yrs disease or condition resulting in death) Due to (or as e consequence of): Examiner ATHERSCLEROSIS CARDIOVASCULAR DISEASE yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting in death) Last Due to (or as a consequence of) Physician/Medical Dua fo (or as a consequence of) Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown RENAL FAILURE P 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed CHRONIC OBSTRUCTIVE DISEASE 1 Yas 2 No 1 ☐ Yes 2 No 25. Was case referred to medical axaminer?
1 Yes No 8 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) group home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 12 Naturel 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifie (Check only 2 Medical Example 2 Š 29b, Signature 29c. License number 29d. Dala signed (Month, Day, Year) mo D32261 FEBRUARY 3, 2000

/Medical Examiner certificate be executed Box 68760. P.O. 9 2 Division of Vital Records, Deed hes

Funeral

Director

28a-fahow must be notified at

ò Nerna 23a

Manyland

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death

pemit. Pages 1 and 2 should be filled within 72 hours effer c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Examina-

Physician

Baitimore, Maryland 21215-0020

physician and s the burlel-transit 180 The lew requires that the death ò page 2 or Attending Physician: director. this After the Funeral Director: Att To the Hospital o within 24 hours af To the Funeral Di completely filled in

10

31. Date filed (Month, Day, Year) FEB 0 4 2000 Registrar

32. Registrer's Signeture

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD J. FEDDMAN, M.D.

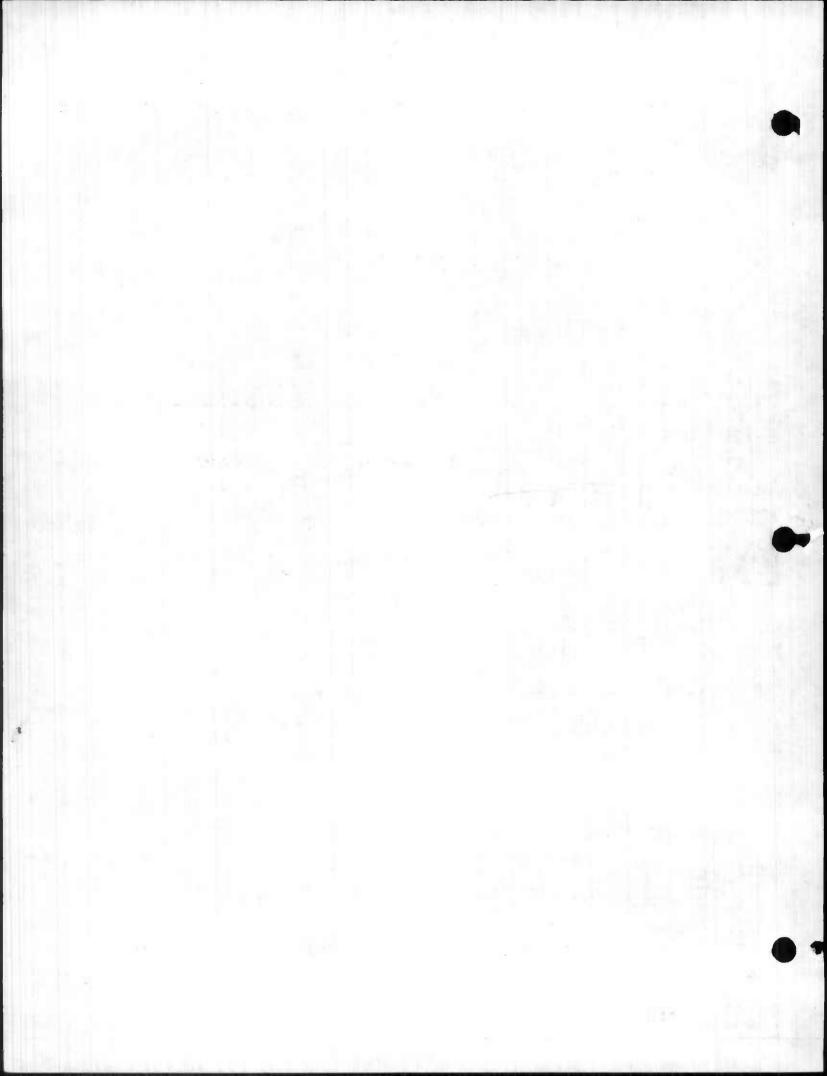
9500 ANNAPOLIS RD, SUITE A-4 LANHAM MD 20706

158 0 4 2000 James M. James Co.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| | | | | | tificate of | | | Reg. No. | 0 08 | 301 |
|----------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------|-------------------------------|--------------------------------------|---------------------|------------------------------|--------------------|------------------|-----------------------------------------------|
| Physician | Decedent's Neme (First, Middle, Martha | Louise | | Th on | | | 2. Dete of Dea Month | Day | Year | Time of Death |
| /Medical | 4a Fecility Name (If not institution, | | er) | Thom | pson | 4b. City. Town, or | Februar Location of Death | | | 442 |
| xaminer | Union Hospital | | ., | | | Elkton | | Ceci | | |
| neral | | | Age (In yrs. | last birthday) | If Under 1 Year Months Deys | If Under 24 Hr | | | | State or Foreign |
| ctor | 222-07-7153 | 1□ M 2(X) F | 82 | Yrs. | MONITIS Days | Hours Mile | July 10 | | | lle, NC |
| Be Completed by Funeral Director | Usuel Residence of Decedent 10a. Slale 10b. County | | 10c City | y, Town or Loc | alion | | | | 10d In | side City Limits |
| 5 | Maryland Cecil | | - | ton | | | | | 100 | ¥ Yes 2□ No |
| Director | 10e. Street and Number | | | | 10f, Zip Code | | | 10g. Citizen of V | What Country? | |
| 0 | Sunbridge Nursin | g Home - | 1 Pric | e Driv | | | | USA | | |
| Funeral | 11. Merital Stetus | 12. Wes Decede | ent Ever in U, | S 13 W | les Decedent of I | Hispanic Origin? (| Specify Yes or No- | 14. Rac | e - American In | dian, |
| F | 1 Never Merried 2 Merried | Armed Force 1 Yes 2 If Yes, Give | | | Yes 2 No | Specify: | no rican, etc.) | | ck, White, etc. | |
| d by | 3 ☑ Widowed 4 ☐ Divorced | Year or Dete | os: | | | оресну. | | Specily | White | |
| Completed | 15. Decedent's (Specify only highest) | Education grade completed) | | (Give I | ent's Usuel Occur | during most of we | orking | 16b. Kind of Bu | usiness/Industry | |
| du | Elementery/Secondery (0-12) | College (1-4 | or 5+) | | O NOT use retire | eu j | | 0 | n Uama | |
| Ce | 4th 17. Fether's Name (First, Middle, La | est) | | Homema | ikel | 18. Molher's Na | ame (First, Middle, | | n Home | |
| To Be | John Parker | | | | | | na Louise | | | |
| - | 19a. Informant's Neme/Reletionship | (Type, Print) | | 19b. Meilin | Address (Stree | | Rural Route Numbe | | State, Zip Code |) |
| | Mildred L. Best | - niece | | 320 W. | Frank1 | in Ave., | New Cast | le, DE | 19720 | |
| 78 | 20a. Method of Disposition | | 20b. P | lece of Dispos | ition (Name of atory or other ple | ace) | Date | 20c. Location - | City or Town, S | itete |
| | 1 ☐ Burial 2 🖾 Cremetion 3 4 ☐ Donelion 5 ☐ Other (Spe | | 916 | | Cremato | - | 2/3/2000 | Hockess | sin, DE | |
| 7 | 21. Signeture of Funeral Service Lie | ensee | | 22. | Name and Addre | ess of Facility | neral Ho | | | |
| | Harvey C. Sn | Ath, Jr. | | | | | . New Ca | | E 19720 | |
| | 23a. Part1. Enler the disease, or co shock, or heart feilure. List on | emplications that causely one cause on eed | sed the death | | | | | | App | oximate val Between |
| | | | | | | _ | | | Ons | et and Death |
| | Immediate Cause (Finel disease or condition | Der | menti | a of t | 1 Caheim | ers typ | e | | ye | ars |
| - | resulting in deeth) | n. | Due to (o | r as a consequ | uence of): | 0' | | | | |
| Examiner | | ■ b. — HV | ricul | tibei/ | alection | | | | 14 | Burs |
| Exal | Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | | Due to (o | r es e consequ | ience of): | | | | i | |
| cal | triat initiated events | c | Due to (or | es a consequ | ence of): | | | | | |
| D | resulting in death) Last | | 10 (01 | | | | | | | |
| Physician/Me | | d | | | | | | | 1 | |
| SICI | Pert II. Other significant conditions | contributing to deal! | h but not resu | ulting in the un | derlying cause gi | iven in Pert I. | 23b. Did t | obacco use co | ntributa to the | cause of death? |
| Phy | Cancer | Brear + | | | | | 101 | res 2□No | 3 Probably | 4 ☑ Unknown |
| l by | | 7.007 | | | | | | | 24b W | denni, fin di |
| etec | | | | | | | 24a. Was a | an autopsy med? | available | utopsy findings e prior to ion of cause |
| Completed | | | | | | | | | of death | ? |
| | | | | | | | 101 | es 2 No | 1 ☐ Yes | 2□ No |
| Be | 25. Was case referred to medical examiner? | Hospitel: | | | | hor | eeth (Check only o | | | |
| T2 | 1 Yes 2 No 27. Manner of Death | 1 lnp | | ER/Outpatient 28b. Time of | 3LI DUA | | Home 5 Resid | - | | |
| tlon | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat | 28a. Date of I (Month, | Day Year) | Injury | M 1 | ork?]Yes 2∐No | Lou. Describe i | .ca aquiy occur | | |
| fica | 3 ☐ Suicide 6 ☐ Could not | be 28e. Place of | Injury - At ho | ome, ferm, stre | et, fectory, office | | 28f. Location (S | | per or Rural Rou | te Number, |
| Certification: | 4 Homicide | building, | etc. (Specify | 1) | | | City or Tow | m, State) | | |
| cal (| 29e. Certifier 1 Certifying I | Physician: To the be | st of my know | wledge, death | occurred et the ti | ime, date and place | ce, end due to the c | cause(s) and ma | anner as stated. | nauca/c) |
| edical | one) | aminer: On the besis and manner | staled. | ion end/or inv | | | | | | |
| Σ | 29b. Signature and title of certifier | K | | | 29c. Licen | | | | d (Month, Day, | |
| | | taelide | NS. | | 100 | 3322 | B, El, | 2/7/ | X000 | |
| | 30. Name and address of person wh | o completed cause | of death (Item | 23a) (Type, F | Print) | C. 42 | 0 50 | 6to mi | 10100 | |
| | 0.3.8407 | DEVINE |) / | | oxia St | oute 3 | 3, 54 | 20011 | 14421 | |
| State | 31. Dete filed (Month, Day, Year) | 32. Regi | strar's Signe | ture | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

| | 1 | Decedent's Nan | ne (First Min | ddle. I as | (1) | | | | | | Death | 1 | 2. Dete of D | Reg. No. | | | 3. Time of Death |
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| ical | 4a | Facility Neme | | | | | | | | | 4b. City, Tow | m, or Lo | cation of Dee | | County | | , |
| iner | ľ | 6701 | 5 RB | DI | | OAO | | | | | HYAT | TSU | ILLE | 88 | eince | GE | ORGES |
| | 5. | Sociel Security | Number | 6. Se | × | 7. Age | (In yrs. | last birthday | | er 1 Yeer | If Under 2 | | 8. Date of B (Month, L | - 1 | 1 | | ce (Stete or Foreign |
| | 5 | 78-16-5 | 501 | 1. | M 2□ F | F | 96 | Yrs. | Months | Days | Hours | Min. | Jan. | | 904 | | h Carolin |
| | | sual Residence o | f Decedent 10b. Coun | ntv | | | 10c City | y, Town or t | ncation | | | | | | | 10 | d. Inside City Limits |
| ō | | 300000 | | • | | | | | | | | | | | | | 1X Yes 2 No |
| Director | - | Iaryland De. Street and Nu | | ice (| George | SS | | Hyatt | | ip Code | | | | 10g. Citi | izen of W | Vhat Countr | y? |
| Ö | | 6705 R | | Roa | ad | | | | | 2078 | 81 | | | | S.A. | | |
| Funeral | 11 | Marital Stetus | | | 12. Was D | ecedent E | ver in U, | ,S. 13 | . Was Dec | | | in? (Spe | cify Yes or N Rican, etc.) | | 14. Race | e - America | |
| Š | | 1 Never Man | | | 1 ☐ Ye If Yes, | Forces? S 2X No Give or Dates: | 0 | | | 2⊠ No | Specify: | Puerto | rican, etc.) | | Specify | k, White, et Wh: | ite |
| ted | | (Sne | 15. Deced | ent'a Edi | ucation | ad) | | 16a. Dec | edent's Us | ual Occup | etlon during most | of worki | na | 16b. Ki | ind of Bu | isiness/Indu | istry |
| Completed | - | Elementery/Sec | | | | e (1-4or 5+ | F) | life. | DO NOT | use retired | d) | | | | | | |
| 3 | - | 12 | /F: | 1 1 1 | | | | Vic | e Pre | sider | nt/Own | | CETTAL ARTHUR | | | in Cab | Co. |
| d C | 17 | 7. Father's Name | | | | | | | | | | | (First, Middl | | Sumam | 16) | |
| 10 | 44 | Mark 2 | | mple | | | | 40h Mai | lline Addre | on (Chanat | | cora | l La | ane | ne Tourn | Ctate Tin (| Pada) |
| | | lyrtle H | | | | | | | | | | | ittsvi | | | | 20781 |
| | - | Da. Method of Dis | | | *************************************** | | 20b. P | Place of Disc | position (N | ame of | | 1190 | Date | - | | City or Tow | |
| | | 1 X Burlei 2 4 ☐ Donation | Cremetion | | | om State | | rt Li | | | | 2 | /2/2000 | Bro | 222 = 12.77 | ood 1 | Maryland |
| | 2 | Signature of Fig. | | | | | FU | | | | ss of Facility | | 2/2000 | Dre | SILCW | 00u, 1 | Maryranu |
| | 1 | | | | | | | | | | | | ne, P.A | \ | | | |
| | | 1.0 | Q.A | - | , | | | | Jascii | Dai | inclai | ALIOI | 10, 1.1 | 7. | | 3.00 | 00701 |
| Je. | In | 3a. Part1. Enter shock, or her mmediate Cause isease or conditions ulting in death) | ert feilure. Li (Final | or complist only o | one cause o | by 40S | e. Cle | h. Do not e | 4739 nter the mo | Balt: ode of dyin | imore . | Aver | nue, Hy or respiretory | atts | vill | | 20781 Approximate intervel Between Onset and Death |
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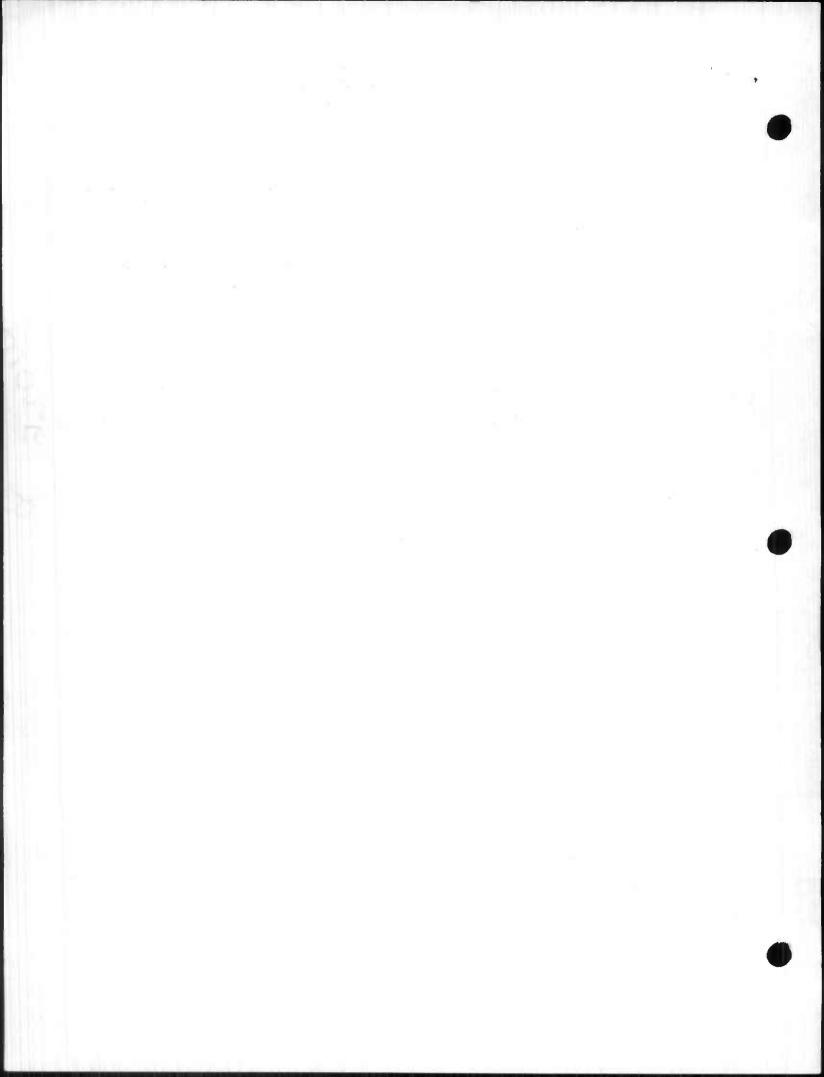
DHMH 16 Rev 6/95

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | IT THE STATE DEPT. OF HEARTH AND MENTAL HYGRENE PRIOR TO DEVIAL, CTETINATION, OF PERMONAL | sd, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the di | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the | be filed within 72 hours after death with the State Dept. of Health and Men | IMPORTANT: If item 28 is marked, or item 23 shows any injur- |

| | FOR STATE REGISTRAR | STATE OF MARYLA | | MENT OF H | | MENTAL HYGIE | | | |
|---------------|------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------|---------------------------------|---------------------|---------------------------------------------|---------------|----------------------|--------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | | | 3. TIME OF DEATH |
| | William Ernest Tal | ob, III | | | | MONTH Z | DAY | OO | 1125 PM |
| | | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) | | 8. BIRTHP Country | PLACE (State or Foreign |
| | 230-03-1910 | X M 2 □ F 81 | YRS. | ONTHS DAYS | HOURS MIN. | July 6, | | | yland |
| ~ | 9a. FACILITY NAME (If not institution, give stree | | | b. CITY, TOWN O | R LOCATION OF DE | ATN | 9c. COU | NTY OF DE | ATN |
| DIRECTOR | 1321 Glenwood Aver | ıue | | На | gerstown | | Wa | ashin | gton |
| 1 | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Washir | igton | Н | agersto | wn | | | | YES 2 NO |
| M | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | 10g. CITI | ZEN OF W | HAT COUNTRY? |
| FUNERAL | 1321 Glenwood Aver | | | | 21742 | | | S.A. | |
| 2 | 11. MARITAL STATUS 1 1 Never Married 2 Married | 2. WAS DECEDENT EVER IN FORCES? 1 X YES | U.S. ARMED 2 NO | | | IIC ORIGIN? (Specify n, Puerlo Ricen, stc.) | res or No- | | - American Indian, White, atc. |
| B | 3 X Widowed 4 Divorced | IF YES, GIVE WAR OR DAT | | | 2 X NO Specify | | | Specify | White |
| | 15. DECEDENT'S EDUCAT | TION | 16a. DECEDENT'S U | SUAL OCCUPATION | DN . | 16b. KIND OF I | USINESS/INC | DUSTRY | WILLES |
| E | (Specify only highest grade con Elementary/Secondary (0-12) | mpleted) College (1-4 or 5+) | (Give kind of wo life. Do NOT use | rk done during mo- retired.) | st of working | | | | |
| 립 | 12 | 1 | Parts . | Analyst | | Refri | gerat | ion E | quipment |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | 18. MOTNER'S NA | ME (First, Middle, Meid | | | 1 |
| BEC | William Ernest Tab | ob, Jr. | | | France | s Elizabe | th Ros | senbe | rger |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 196. MAILINO A | ODRESS (Street a | | Ploute Number, City or | | | |
| - | Sally T. Wilkerson | ı — Daughter | 410 W | est Vir | ginia Av | enue Cre | we, V | irgin | ia 23930 |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remove | | PLACE AND DATE OF | | | DATE 20c. | LOCATION — | City or Tow | vn, Stata |
| | 4 Donation 5 Other (Specify) | | tery, cremetory or other agerstown | Cremat | ory | H. | agerst | own, | Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE . | _// | | | CILITY Minni | | | |
| | COUNT | 1/um | uch | 415 E | . Wilson | Blvd. H | agerst | town, | Maryland |
| | 23. PART I. Enter the diseeses, or cor shock, or heart failure. Lis | nplications that ceused | the death, Do no | 1 enter the mo | de of dylng, auc | h se cerdiec or re | piretory an | reat, | Approximate |
| ł | IMMEDIATE CAUSE (Final | - | | | | 1 | | | Onset and Death |
| | disease or condition resulting in death) | (42) | 10/2/2 | PIRA | -1321 | /TRA | 12-5 | / | |
| | | DUE TO (OR AS A | CONSEQUENCE OF) | 10100 | cma | April CAR | 110 | ma | |
| O | Sequentially list conditions, b. | DUE TO (OR AS A I | CONSEQUENCE OF | -UZIVA | SITTI | 2 | - 6 | 1 | - |
| ΕĮ | if any, leading to immediate cause. Enter UNDERLYING | | | | 9/ | NOS FA | 7/=- | | j |
| | CAUSE (Diseese or injury that initiated events | | CONSEQUENCE OF) | | 1 | | | | |
| CERTIFICATION | reaulting in deeth) LAST | | | | | | | | |
| | PART II. Other aignificant conditions | contributing to death bu | t not married as In | the underlying | n navon élven la | non i Tou uno | AN AUTOPSY | 1 | |
| 정 | PART II. Other alginicant conditions | contributing to deeth bu | t not resolting in | the underlying | g ceuse given in | PERI | ORMED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | | 1 □ YES | 2 NO | | OF DEATH? |
| Σ | DID TOBACCO USE CONTRI | DITE TO CALISE OF | DEATH VE | ПИОБ | UNCERTAIL | | | | t YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 6. PLACE OF DEATH | | UNCERIAII | N L | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | OTHER: | a & Consideran | 8 Other (Specify) | | | |
| H | 27. MANNER OF DEATN | 28a. DATE OF INJURY | 28b. TIME | OF 28c. INJ | URY AT | 28d. DESCRIBE NO | W INJURY OC | CURED | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJU | | YES 2 NO | | | | |
| Э ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJURY - building, stc. (Specif | At home, farm, at | reet, factory, offic | | 281. LOCATION (Stre | | r or Rurel R | oute Number, |
| | 4 Homicide determined | barrang, etc. (opoci | ,, | | | City or Town, St | itu) | | _ |
| 1 2 | Check only 1 CERTIFYING PNYSICIA | AN: To the best of my knowle | dge, death occurred | at the time, date | and place, and due | to the cause(s) and | menner as ata | rted. | |
| COMPLETED | (000) | On the basis of examination | and/or Investigation | , in my opinion, d | eath occured at the | time, data and place, | and dua to ti | he cause(s) | and manner as stated. |
| Ö | 296. SACHATURE AND TITLE OF CERTIFIER | 11 2 | | | 29c. LICENSE NUI | MBER-1201 | 29d. DAT | TE SIGNED | (Month, Day, Year) |
| 0 | Jage a. 1 | Muse | 2 | | D06: | 72 8.900 | 1 1 | 128 | 100 |
| 임 | 30. NAME AND IDDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TN (ITEM 27) (Type, I | Print) | ^ | | | | 1 |
| | WAGNE A. | · mui | u (su | 3, 1 | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | 1 | | | | | |
| | JAN 2 8 2000 | Deneva | Ø. | BOW W. | 2/ | | | | |



| Plea | se Type or Pri | | | | | | | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------|----------------------------|--------------------------------------------------|----------------------------------------------------------|----------------------------------|----------------------------------------|----------------------------------------------------|
| | State of M | aryland / | | irtment of <i>tificate of</i> | Health and N Death | | giene | 05304 |
| 1. Decedent's Name (First, Middle | s, Last) | | | | | 2. Date of Dea | | 3. Time of Death |
| Bruce Denny | Trexler. | Jr. | | | | Jan. | 29, 2000° | 2:15 P.M. |
| 4a Facility Name (If not institution | | | | | 4b. City, Town, or L | 1 | | |
| Crofton Conv | alescent 8 | & Reha | ab. (| Center | Crofton | | Anne A | rundel |
| 5. Social Security Number | | ge (In yrs. last | | If Under 1 Year | r If Under 24 Hrs. | 8. Date of Birt | h 9.1 | Birthplace (State or Epreign |
| 250-10-6898 | 15€M 2□ F | 81 | Yrs. | Months Days | Hours Min. | July 3 | 4 0 4 0 | South Carol- |
| Usual Residence of Decedent | | | | | | | | Journ Culor |
| 10a. State 10b. County | | 10c. City, To | own or Loc | cation | | | | 10d. Inside City Limits |
| Md. Princ | e Geoges | Bow | /ie | | | | | Yes 2□No |
| 10a. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of What | Country? |
| 3510 Majest | ic Lane | | | 207 | 15 | | USA | |
| 11. Maritel Status 1 Never Married 2 Marr 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 16 Yes 2 If Yes, Give Year or Dates: | ? | 01 | Vas Decedent of Yes, specify Cul | Hispanic Origin? (Sp ban, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - A Black, W Specify: W | THE SECOND |
| 15. Decedent (Specify only highes | | 10 | (Give I | ent's Usual Occu | during most of work | sing | 16b. Kind of Busine | ss/industry |
| Elementary/Secondary (0-12) | College (1-4or) | 5+) | | cher/Yo | , | nselor | Reform | School |
| 17. Father's Name (First, Middle, | Last) | | | | 1 | | Maiden Sumame) | |
| Bruce Denny | Frexler, S | r. | | | Mamie | Pick | ler | |
| 19a. Informant's Name/Relations | hip (Type, Print) | 1 | 19b. Meilin | g Address (Street | at and Number or Rui | ral Route Numbe | er, City or Town, State | e, Zip Code) |
| Maureen Wade | - Neice | | 3510 | Majes | tic Lane | , Bowi | e, Md. 2 | 0715 |
| 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) | | 20b. Place ceme | e of Dispos etery, crem | sition (Name of natory or other pl Cemete: | ace) | Date | 20c. Location - City 0 Sumter | |
| 21. Signature of Funeral Service Shannon W. | W. Beall - | / M0079 | | Name and Add | B | | uneral H Bowie, | |
| 23a. Part1. Enter the disease, or shock, or heart laiture. List | only one cause on each li | ine. | Do not ente | er the mode of dy | ring, such as cardiac | or respiratory ar | rrest, | Approximete Interval Between Onset and Death |
| Immediate Cause (Finet disease or condition resulting in death) | · upper (| Grast- | 10_In | testin | al ble | redir | 9 | weeks |

Physician /Medical Examiner

The lew requires that the death certificate be swacuted

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Finet disease or condition resulting in death)

Medical Certification: To Be Completed by Physician/Medical Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the funeral director, filled in by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

4 Homicide

29a. Certifier

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or home 23a or 23a-f show any injury or other treumatic event, the Heades Examinar must be not the doats.

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

Atherosclerotic

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yea 24a. Was an autopsy performed? 26. Place of Death (Check only one)

25. Was case referred to medicat axaminer? 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 5 Pending investigation 3 ☐ Suicide

6 Could not be 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29c. License number D20108

Other:

28c. tnjury at Work?

29d. Date signed (Month, Day, Year) 31 00

3 Probably 4 Unknown

24b. Wera autopsy lindings available prior to completion of cause of death?

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora MD 31. Date filed (Month, Day, Year) FEB 0 1 2000

14300 Gallant Fox Lane, Bowie, Md. 20715 32. Registrar's Signature

28b. Time of Injury

State Registrar

completely

DHMH 16 Rev 6/95

within 24 hours after death.

To the Funeral Director: After this certificate hea

To the Hospital or Attending Physicien:

3000 10 030 000 10 030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | State o | of Marylan | | tificate of | | d Mental Hy | giene (| 050 | 305 |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------|----------------------------------|-------------------------------------------------------------|------------------|------------------------------------------|------------------------|--------------------|----------------------------------------------|
| Physician | 1. Decedent's Nema (First, Middle, I | | | | | | 2. Date of De Month | eath Day | Yaer | ime of Death |
| Physician /Medical | -4 | inson | | | | | Jan. | 26 2 | | 30AM |
| Examiner | 4a Facility Nema (If not institution, g | | mber) | | | | or Location of Deat | , | | -1- |
| | 4415 Dario Road | | 7 4 (10 | to and the feether when a bill | If Under 1 Year | ~ ~ | Marlboro | | e Georg | |
| neral ector | | Sax 1□M 2ÃF | 7. Age (In yrs. | Yrs. | Months Deys | | Ain. (Month, De | y. Year) | Country) Richmon | Steta or Foreign |
| or | 227-30-1629 Usual Residence of Decedant | | 81 | | | | rep. Z | 7, 1910 | RICHMON | iu, vA |
| | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | 10d. Ins | side City Limits |
| 5 | MD Prince | George's | s Uppe | er Mari | lboro | | | | 12 | Yas 2□No |
| Funeral Director | 10e. Street and Number | | - I - F L | | 10f. Zip Code | | | 10g. Citizen of 1 | Whet Country? | |
| | 4415 Dario Road | 3 | | | 207 | 72 | 134 | USA | | |
| Jera | 11. Marital Status | 12. Was Dec | edent Ever In U | ,S. 13. \ | Was Decedent of I | Hispenic Origin? | (Specify Yes or No uerto Rican, etc.) | o- 14. Rad | ce - American Ind | lian, |
| | 1 Nevar Marriad 2 Married | Armed Fo | 2 No | | - 1 | | uerto Hican, etc.) | | ck, White, etc. | |
| ı | 3 ☑ Widowed 4 ☐ Divorced | If Yes, Gir Year or D | ve latas: | | I□Yas 2Ã No | Specify: | | Specify | y: Diack | |
| combined as | 15. Decedent's (Specify only highest of | Education | | 16a. Deced | tent's Usuel Occu kind of work done DO NOT use retire | pation | working | 16b. Kind of B | usiness/Industry | |
| | Elementery/Secondery (0-12) | College (| 1-4or 5+) | life. I | DO NOT use retire | 9d) | | | | |
| 1 | 4 | | | D | omestic | | | | te Indus | stry |
| | 17. Father's Nama (First, Middla, La | st) | | | | | Name (First, Middle | | na) | |
| | Edward Burnett | | | | | | abeth Moo | | | |
| | 19a. Informant's Name/Relationship | | | | | | r Rural Route Numb | | |) |
| | Marrell Johnson | n/Grands | | | | | r Marlbon | | 20772 | |
| | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 | □ Bemoval from | State 20b. F | Plece of Dispo cematary, crer | sition (Neme of natory or other pla | ace) | 01/28/200 | | - City or Town, S | tate |
| 1 | 4 Donelion 5 Other (Spec | | Ri | lverda1 | e Park (| Cremator | y 01/20/200 | | dale, M | D |
| | 21. Signatore of Funerel Service Lig | 110 | | | . Nama and Addr | - | | | | |
| | 7 Lunas A | Bun | relee | Ту | | | uneral Se | | 20017 | |
| | 23a. Part1. Enter the diseese, or co | mplications that | caused the deat | h. Do not ent | er the mode of dy | ing, such es car | diec or respiretory | errest, | Appr | oximate val Between |
| | shock, or heert feilure. List on | ny one ceuse on e | ecn inte. | | | | | | Onse | at and Death |
| | Immediate Cause (Final disease or condition | Acu | te Myoc | ardia1 | Infarct | i on | | | 1 1 | hr. |
| | resulting In death) | a | - | or as e consec | | | | | | |
| dical Examiner | | Cor | | | Disease | | | | 10 | yrs. |
| | Sequentially list conditions. | b | Due to (d | or es e consec | juence of): | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents | | | | | | | | 1 | |
| 2 | that initiated avents resulting in death) Last | С. | Dua to (o | r as a consaq | uance of): | | | | | |
| Zec | . Southing in Steam Last | | | | | | | | | |
| Physician/Me | | d | | | | | | | | |
| SICI | Part II. Other significant conditions | contributing to d | eath but not res | uiting in the u | nderlying cause g | iven in Part I. | 23b. Did | tobacco use co | ontributs to the o | suse of death? |
| 1 | Hypertensive | Heart Di | 52542 | | | | 10 | Yes 2 No | 3⊠ Probably | 4 Unknown |
| ١ | Typer censive . | ileare DI | Deuse | | | | | | 1 | |
| | Chronic Obstr | uctive P | ulmonar | y Dise | ase | | 24e. Was | s an autopsy ormed? | available | topsy findings a prior to ion of cause |
| | | | | | | | | | of death | ? |
| ı | | | | | | | 10 | Yes 200 No | 1 ☐ Yes | 2□ No |
| ŀ | 25. Was case referred to medical | | | | | 26. Place of | Death (Check only | one) | | |
| | examiner? | Hospital: 1 | Inpatient 2 | ER/Outpatier | nt 3 DOA | ther: 4 Nursir | ng Home 5 🖾 Res | idence 6 Dot | her (Specify) | |
| | 27. Menner of Death | 28e. Date (Mon | of Injury th, Dey Year) | 28b. Time of Injury | 28c. Inju | ury et ork? | 28d. Describe | how injury occu | rred | |
| 1 | 1 Naturel 5 ☐ Pending investigat | tion | | ,, | | Yes 2□No | | | | |
| - Common of | 3 Sulcida 6 Could not determine | 288. PIECE | of Injury - At h | ome, farm, str | reet, factory, office | | 28f. Location City or To | (Street and Num. | ber or Rural Rou | te Number, |
| | - CHAMIOUS | Dullo | g, att. (apacii | 7/ | | | 0.17 | | | |
| | | | | | | | laca, end due to the | | | Pauco(s) |
| edicai | (Check only 2 Medical Ex | | asis of examina nner stated. | ition and/or In | vestigetion, in my | opinion, deeth o | occurred at the time | , dete and placa, | end due to the d | ause(S) |
| 3 | 29b. Signeture and title of cartifier | 1 | | , , | 29c. Licen | nse number | | 29d. Date signe | ed (Month, Dey, ' | Year) |
| | heur. | UMI | arch | all | MD MD | 25618 | | 1 - 2 | 7 - 2000 | |
| 1 | 30. Name and address of person wh | no completed caus | se of death (Iter | n 23e) (Type, | Print) | | | | | 115 |
| | Louis Marshall | M.D. | 1160 Va | rnum S | treet, N | E Wash | ., DC 20 | 017 | | |
| j | 31. Data filed (Month, Dey, Yeer) | | Registrar's Signa | ature | | -9 | | | | |
| е | 1011 - 4 200 | n Z | | | | | | | | |

DHMH 16 Rev 6/95

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| Please | Type or Print in State of Marylar | | | | | | - | _ | ible. | 15306 |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------|---------------------------------------------------|----------------|----------------------|----------|-----------------------------------|------------------|------------|--------------------------------------------------------------------------------|
| | | (| Certificate | of | Death | | R | a. No. | | , 5000 |
| 1. Decedent's Name (First, Middle, Las | st) | | | | | | 2. Date of Deat | | 17500 | 3. Time of Death |
| MARTHA WIDME | R UNDERHILL | | | | | | JAN 2 | Day 8 2000 | Year | 1:18 AM |
| 4a. Fecility Name (If not institution, give | | | | - 4 | b. City, Tow | n, or Lo | ocation of Death | 4c. County | y of Death | |
| NATIONAL NAVAL | MEDICAL CENT | ER | | | BF | THES | SDΔ | , | MONTO | GOMERY |
| 5. Sociel Securify Number 8. So | | | day) If Under 1 | | If Under 2 | 4 Hrs. | 8. Date of Birth (Month, Day, | | | |
| 496-18-0968 | □M 2ĬF | 79 Yr | s. Monfhs D | Deys | Hours | Min. | APR 16, | 1920 | | plece <i>(State or Foreig</i> Intry) SSOURI |
| Usual Residence of Decedent | | | | | | | min 10, | 1720 | PIL | SOURT |
| 10a. State 10b. County | 10c. Ci | ty, Town o | or Location | | | | | | | 10d. Inside City Limits |
| VIRGINIA FAIRFAX | ΔN | NAND | ΔT F | | | | | | | 1 ☐ Yes 2X No |
| 10e. Street and Number | 111 | TILLIAD: | 10f. Zip Co | ode | | | 1 | Og. Citizen of | What Cor | intry? |
| 4824 CANDACE LANE | | | 220 | 000 | | | | | | , |
| 11. Maritel Stetus | 12. Wes Decedent Ever in L | S | 220 | | ispanic Orio | in? (Sn | acify Yas or No- | U.S.A. | | ican indian. |
| 1 ☐ Never Merried 2 🗓 Married | Armed Forces? 1 ☐ Yes 2 ☑ No | ,0. | Wes Deceden If Yes, specify | Cuba | n, Mexican, | Puerto | Rican, etc.) | | ck, White | |
| 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Deles: | | 1□Yes 2X | No | Specify: | | | Specif | y: WHI | er e |
| 15. Decedent's Ed | | 160 D | ecedent's Usual C |)ccun | etion | | | 16b. Kind of B | | |
| (Specify only highest grad | de completed) | (0 | Give kind of work of | done i | during most | of work | Ing | . Jo. Airid UI D | Jon 1083/1 | radally |
| Elementary/Secondary (0-12) | College (1-4or 5+) | | EMAKER | | | | | OWN H | OME | |
| 17. Father's Name (First, Middle, Last) | | 11011 | | | 18. Mother | 's Name | (First, Middle, I | | | |
| JOSEPH MARTIN W | TIMED | | | | | 507E3 | | | | |
| 19a. Informant's Name/Relationship (7 | | 10h l | Mailing Address (S | Nun nt | | | J. BOHI | | Ctata 7 | (in Control) |
| | | | | | | | | City or Town | , State, Z | р Соав) |
| EDWARD G. UNDERI | | | 4 CANDAC | | JANE | ANN | ANDALE, | VA 220 | | Carra Otata |
| 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ | Removel from State | cemetery, | cremetory or othe | r plac | | 1 | | 20c. Location | | |
| 4 Donation 5 Dother (Specify | ARI | LINGT | ON NATIO |)NA | L CEME | ETER | Y 02/03 | ARLING | TON, | VIRGINIA |
| Immediete Cause (Finel disease or condition resulting in death) | a. ACUTE PULM | | EDEMA | | | | | | | Interval Between Onsef and Death |
| Sequentially list conditions, | b. Due to (| or as a cor | nsequenca of): | | | | | | 1 | |
| if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 0 | | | | | | | | 1 | |
| thet initiated events resulting in death) Lasf | Due to (c | or as e cor | nsequence of): | | | | | | 1 | |
| | | | | | | | | | 1 | |
| Part II. Other significant conditions co | entributing to death buf not res | ulting In th | ne underlying caus | se giv | en in Part i. | | | bacco use co | | to the cause of death |
| | | | | | | | 24a. Was a perform | | 8 | Vere autopsy findings vallable prior to completion of cause of death? |
| | | | | | | | 1 🗆 Y | s 2 No | 1 | ☐ Yes 2☐ No |
| 25. Was case referred to medical | | | | | 26. Place | of Deatl | Check only on | θ) | | |
| examiner? 1 ☐ Yes 2 ☑ No | Hospitai: 1 Inpatient 2 | ER/Outpo | atlent 3 DOA | Oth | er: 4 🗆 Nur | sing Ho | me 5 Reside | nce 6 🗆 Ott | her (Spec | ity) |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation | | 28b. Tim inju | ne of 28c. | . Injur Wor | yaf k? Yes 2□N | | 28d. Describe ho | w Injury occu | rred | |
| 3 Sulcide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At h building, etc. (Special | ome, farm | , street, factory, o | office | | | 28f. Location (St City or Town | | ber or Ru | ral Route Number, |
| (Check only 2 Medical Exam | reician: To the best of my kno iner: On the bests of examina end menner steted. | | or Investigation, In | my o | pinion, death | | ed at the time, d | ate and place, | and due | fo the cause(s) |
| 29b. Signature and title of certifier | lun mi | 2 | 29c. L | 1 | 6000 (| | | ed. Dete signe | 2 & | (Day, Year) |
| 30. Name end address of person who o | ompleted cause of death (Item EN, LT, MC, US | | rpe, Print) | | | | AVAL MEI D 20889- | | ENTE | R |

State Registrar

Physician

/Medical

Examiner

Funeral

Birector

Parmit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Devertment of Health and Mentel Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Eventne must be notified at once.

Physician /Medical

Examiner

nding physician and use es the buriel-transit

ettending

been signed by the etter should be deteched for

page 2 should

After this certificate has

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifical liely filled in by the funeral director,

The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Directo

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medical

31. Date filed (Month, Day, Year) FEB 0 3 2000 32. Registrar's Signature

footh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Part 1. Per Phys. PGC 2-2-2000 cr Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Stanley F. Vausse January 21, 2000 9:56 am 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1⊠M 2□F Months Jan. 28, 1920 New York 577-38-0892 79 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2313 Banning Place 20783 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Black, Whita, etc. 1 N Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 🖾 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Auditor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Effie Virginia Myers Franklin Pierce Vausse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Margritt Vausse - Wife 2313 Banning Place, Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 01/27/00 Alexandria, Virginia 4 Donetion 5 Other (Specify) Metropolitan Crematory 21. Signeture of Funerei Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 2 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. PertT. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finel NEUMONIA diseese or condition resulting In deeth) Due to (or as a consequence of): SPIRATION **PNEUMONTA** AL2HEIMER 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No

Physician /Medical **Examiner**

sician and burial-transit

the

signed by d be detact

page 2

certificate

this

il or Attending Pi safter death. I Director: After t

To the Hospital of within 24 hours at To the Funeral Discompletely filled Delli

6

Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medical

Physician

/Medical

Director

Funeral

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Examiner

Funeral

Director

288-4

b must be

Nerna 23a

8

Hygiene.

Department of Health and Mental Hy Important: If Item 27 is mented other any Injury or other to

attar

hours

21215-0020

Baltimore, Maryland

Box 68760

P.O.

Records,

of Vital

Division

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

STROKE

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No 27. Menner of Death 1 Neturel 2 Accident

3 Suicide

4 Homicide

28e. Date of Injury (Month, Day Year) 5 Pending Investigation 6 Could not be

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier u courpess.

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

Erensto 31. Date filed (Month, Dey, Year) FEB 0 2 2000

Ofricano 32. Registrer's Signeture

University Blod. Silver Spring

State Registrar

DHMH 16 Rev 6/95

FEB-0 2 2000

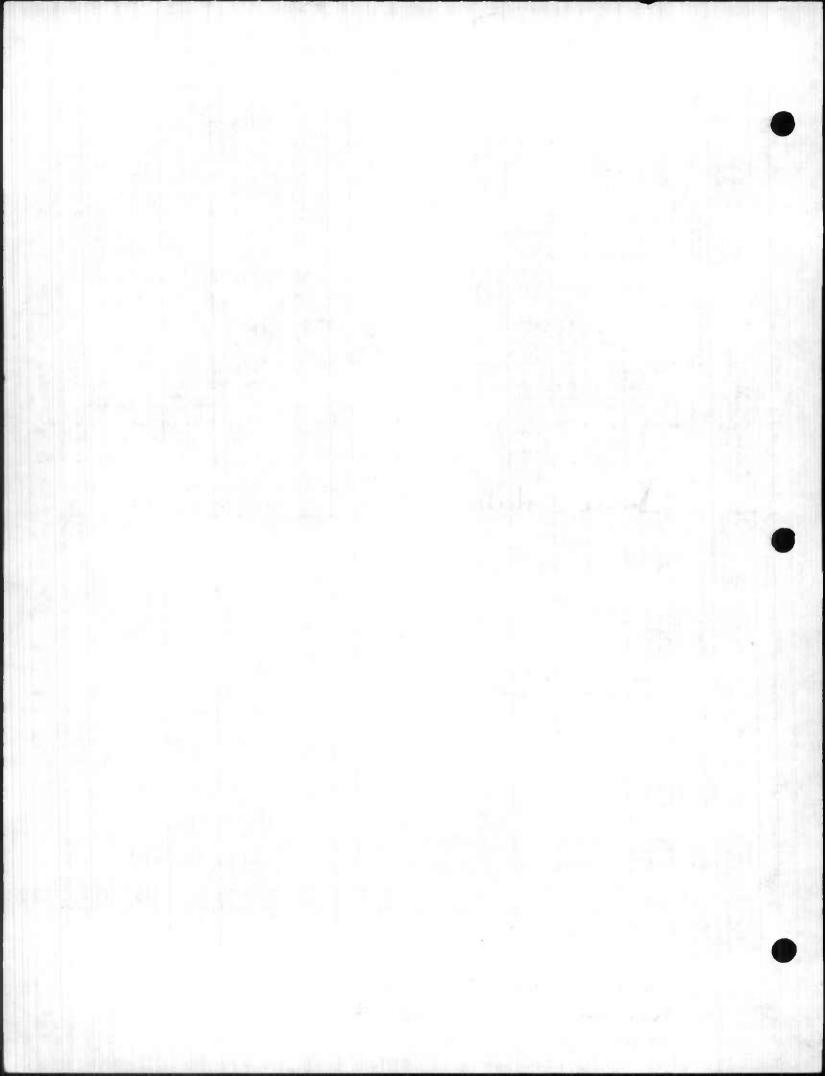
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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|-----|----|----|-----|-----|
| 1 1 | 23 | 16 | 1 1 | 1 1 |
| U | N. | 1 | 10 | 11 |

| | | | | | Cert | ificate | of Death | F | leg. No. | | | | |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------|---------------|----------------------------|-------------------------------|---------------------|------------------|----------------|-------------------------------------|--|--|
| | 1. Dece | dent's Name (First, Middle, L | est) | | | | | 2. Date of Dea | th | | 3. Tima of Death | | |
| nysician Medical | | Louise | Rena | Ver | een | | | Month Februar | y 5, 20 | Year | 2345 P | | |
| xaminer | 4e Facil | ity Name (If not institution, gi | va street and number) | | | | 4b. City, Town, o | r Location of Death | 4c. County | of Death | | | |
| | 714 | Sunbridge Ca: | re Center | | | | Elkton | n | Ce | cil | | | |
| eral | 5. Social | | | ge (In yrs. last b | irthday) | If Under 1 \ | | | (Vaer) | 9. Birthpla | ace (State or Foreign | | |
| tor | 263-34-7570 1 M 2 F 94 Yrs. Months Days Hours Min. (Month, Day, Year) Country) August 11, 1905 Kansas Usual Residence of Decedent | | | | | | | | | | | | |
| Irector | 10a. Sta | te 10b. County | | 10c. City, To | wn or Loca | tion | | | | 100 | d. Inside City Limits | | |
| o | Mar | yland Ceci | 1 | Elkt | on | | | | | | 1 No 2 No | | |
| Director | | | | | | | | | | | | | |
| | 253 | East Main St | reet | | | 2 | 1921 | | Unite | d Stat | tes | | |
| Funeral | 11. Meri | tal Status | Specify Yes or No- | | e - American | | | | | | | | |
| by | 3 🖄 | Never Married 2 Married Widowed 4 Divorced | No | | | No Specify: | orto Rican, etc.) | Specify | ck, White, el | | | | |
| 8 | | 15. Decedent's E | | 16 | a. Decede | nt's Usual O | ccupation | | 16b. Kind of B | usiness/Indu | estry | | |
| Completed | Fleme | (Specify only highest gr entary/Secondary (0-12) | rade completed) College (1-4or | 54) | (Giva kii | nd of work of NOT use r | orking | | | | | | |
| E | | 12 | College (1-40) | 34) | Home | emaker | | | In her | own l | home | | |
| BeC | 17. Fath | er's Name (First, Middle, Las | () | | | | 18. Mother's N | ame (First, Middle, | Maiden Suman | na) | | | |
| ToB | | James Garfie | ld Jones | | Jes | sie Talbo | tt | | | | | | |
| - | | ormant's Name/Relationship | (Type, Print) | 19 | b. Mailing | Address (S | treet and Number or I | Rural Routa Numbe | r, City or Town, | Stata, Zip C | Code) | | |
| | 1 | sie L. Andrew | | | | | ain Stree | | | | | | |
| | | thod of Disposition | | 20b. Place | of Disposit | tion (Nama | of | Date | 20c. Location | | | | |
| To Be Completed by | | Burial 2 Cremation 3 Donation 5 Other (Special | | | | cony or other | | 2/11/00 | Lake W | ales, | Florida | | |
| DUCE | 21. Sign | eture of Funeral Service Lice | msee | | Hic | cks Ho | ddress of Facility ome for Fu | | | .1 3 | 21021 | | |
| | 23a. Pa | rt1. Enter the disease, or conock, or heart tailure. List only | nolications that cause | d the death. Do | | | tockton S | | | | Approximate | | |
| ian | sh | ock, or heart tailure. List only | one cause on each li | ne. | | | | | | | Interval Between Onset and Death | | |
| cal | Immedia | ate Cause (Final | 77 | | | | | | | | | | |
| er | disease | disease or condition resulting in death) a. Shur with In Gir know with | | | | | | | | | | | |
| 1 | | Due to (or as a consequence of): ARTERIOS CHENOTIC CHADIOUNS CLEUPE DISEMSE 3 9844/ | | | | | | | | | | | |
| _ = | | | b. ARTE | RLOSCU | ENOT | 2C C | anoiden | SCIELTR | DISETH | 861 | 3 gear | | |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. ALZHOLWINE \$\frac{1}{2} \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \subseteq \ | | | | | | | | | | | | |
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| edical | I THAT ITHER | that initiated events resulting in death) Last Due to (or es a consequence of): | | | | | | | | | | | |
| 2 | | 1 year | | | | | | | | | | | |
| an | 1 | | 0. | | | | | | | | | | |
| SICI | Part II. O | ther significant conditions | contributing to death b | 23b. Did to | obacco usa co | ntributa to t | the cause of death? | | | | | | |
| / Physician/ | | | | | | | | 1 🗆 Y | aa 2010 | 3 Probe | ably 4 Unknow | | |
| leted by Physician/ | | | | | | | | 24a. Was a | n autoney | 24h Wer | re autopsy tindings | | |
| e e | | | | | | | | perfor | | avail | lable prior to | | |
| Completed | | | | | | | | | | ot de | eath? | | |
| Ö | | | | | | | | 1 🗆 Y | es 2 PNo | 10 | Yes 2010 | | |
| 9 | | case referred to medical | | | | | 26. Place of D | eath (Check only or | na) | | | | |
| 2 | 10 | | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho | | | | | | ence 6 Oth | ner (Specify) | , | | |
| | 4 | ner of Death | 28a. Date of Inju (Month, Da | ry 28b. | Time of | 28c. | Injury at Work? | 28d. Describe h | ow Injury occur | red | | | |
| Certification: | 30 | Vatural 5 ☐ Pending Accident investigatio Suicide 6 ☐ Could not to determined | pe 28e. Place of Inj | ury - At home, I | Injury | М | 1 ☐ Yes 2 ☐ No | 28f. Location (S | | ber or Rural I | Routa Number, | | |
| Medical Certification: 1 | 70 | TOTALO | Collumg, et | c. (Specity) | | | | City or Tow | n, State) | | | | |
| edical | 29a. Cei (Ch | eck only 2 Medical Exa | hysician: To the best miner: On the basis of and manner st | examination a | | | | | | | | | |
| × | 29b. Sig | nature and title of certifier | | -100. | | 29c. Li | cense number | 2 | 9d. Date signe | d (Month, Di | Pav. Year) | | |
| | N | O 00 0 | 1.51 | | | | | | | | | | |
| | - | Juniste. | m, c | | | 0 | 07463 | | 2-1 | 1-00 | | | |
| | 30. Name | a and address of person who | completed cause of d | leath (Item 23a) | (Type, Pr | int) | | | | | | | |
| | Ro | olando Najera, | M.D. | 111 W. | High | Stree | et, Elkton | , MD 219 | 921 | | | | |
| State | | filed (Month, Day, Year) | 32. Registr | ar's Signature | dos | 161 | | | | - | | | |
| -leanen | (a.) | FRA 8 2000 | 1 1000 | 100 | Die O | | | | | | | | |



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Yaar Month Patricia Montague Halpine Venable 28 2000 0356 Jan. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis 8. Deta of Birth (Month, Day, Year) h 22, 1927 Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days Hours 1□ M 2♥ F 577-38-5515 73 Hawaii Territory Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. toslde City Limits 1 ☐ Yes 2 💢 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1106 Mainsail Dr. 21403 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Giva 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Nicholas J. Halpine Emily Montague 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) Jack D. Venable / Husband 1106 Mainsail Dr. Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 02-02-00 Alexandria, Virginia 22. Name and Address of Facility Carvice Licensee John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Olies Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? stroesophageal Reflux thritis of Knee 2 No 1 □ Yas 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examines

Physician

/Medical

Examiner

Directo

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Funeral

Director

28a-f

Nerra 23a or

filed within 72 hours after

Pages 1 and 2 should be III mant of Health and Mental H ant: If Nem 27 is marked off lury or other traumatic even

21215-0020

altimore, Maryland

the signed by the at the detached for After 24 hours after death.

Funeral Director: A filled in by

The law requires that the death certificate be asscuted

Box 68760.

P.O.

Division of Vital Records.

Physician:

or Attending

Hospital

within 2 To the

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Certification: To Be Completed by Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier edical

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

29b. Signatura and titla of certifiar Hausman MO Ceshon,

D27388

Jan 28, 2000

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

900 BestgateRd#303, Aunapolis MD 21401 A. Stephen HANSMAN 31. Date filed (Month, Day, Year)

State Registrar

FEB 0 1 2000

FEB 01 2000 James B. Gerald

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 11:00 am 25, 2000 January Emily Catherine Vassar /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie Mariner Nursing Home
5. Social Security Number 6. Sex If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Mar 27, 1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1□ M 2Q F Hours 81 220-16-2161 Director Maryland Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Severna Park 1 Yes 2 No Director MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 413 Fernwood Drive Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No 1 Never Merried 2 Merried 21215-0020 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify. þ White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filled within nent of Health and Mental Hyglena. Int: If itam 27 is marked other than ' ury or other traumatic avant, the Me Elementary/Secondary (0-12) College (1-4or 5+) Houseparent of Juvenile Home State of Maryland 12 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Edith Mae Poe George Schaeffer 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Fernwood Drive, Severna Park, MD 21146 Wayne Gaver/ son 20a. Method of Disposition 20b. Ptece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Remove from State Jan 29 Old Oakland Church Cem. Sykesville, MD 2000 23: Signature of Fuperal Service Lie 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Do not enter the mode of dying, such as cardiec or respiretory arrest, Physician /Medical Cause (Final ARDIOVASCUCAR Examiner Due to (or as a consequence of) Completed by Physician/Medical Exam Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): certificate be exe Box 68760, 2 Due to (or es e consequence of): = 3 The law requires that the death Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I, 23b. Did tobacco usa contributa to the causa of death? Division of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown ARTERIAL 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? CHRONIC RENAL FAILUR completion of ceuse of death? DEMENTIA 1 Yes 24 No 1 Yes 2 No or Attanding Physician: 25. Wes cese reterred to medicel examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Affer 5 Pending 1 Tyes 2 □ No 24 hours after death. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) within 2. To the F To the 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) Lous 30. Name and address of ed caus of death (Item 23a) (Type, Print) erson who comple

DHMH 16 Rav 6/95

State

Registrar

uchar 31. Date filed (Month, Day, Year)

FEB 02

32. Registrer's Signature

from B. Leville

FEB 9 2 2000

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** VIVIAN VALENCIA Jan. 2000 6:23AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Months Days Hours 85 Yrs. June 12, 1914 Wash., 578-26-2944 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Prince George's Temple Hills Directo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4921 Temple Hill Road 20748 IISA Funeral death Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: Black by 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. other than College (1-4or 5+) Elementery/Secondary (0-12) Private Industry 11 Nursing nd 2 should be filed lith end Mental Hygid 27 Ia marked other r traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Ferdinand Dews, SR. Mary Coles 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Department of Health end Important: If item 27 Ia m any Injury or other traum Fariece Altice/Sister 7324 Donnell Place #C2 Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 1/31/2000 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Veterans Cemetery Baltimore, Maryland 22. Name end Address of Fecility Tyrone J. Young Funeral Services rownle 719 Kennedy St., NW Wash., DC 20017 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Congestive Heart Failure **Examiner** Due to (or as a consequenca of): Examiner Myocardial Infarction certificate be axecuted attending physician end for use es the burial-tran Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Diabetes Mellitus Box 68760. Physician/Medical that initiated events resulting in deeth) Lest Due to (or as a consequence of): P.O. ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4₺ Unknown Chronic renal failure signed t Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed Acute bronchitis paga 2 certificata has Cerebral Vascular Disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: After Attending 1 Natural 5 Pending s effer death. 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 6 Hospital 24 hours 29a. Certifier 🖎 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. edicai To the Hosp within 24 hos To the Fune completely fi 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 1/23/2000 D34472 30. Name and address of person who completed cause of Geath (New 23a) (Type, Print)

Lynne D. Diggs, MD 1500 Forest Glen Road 20910 Silver Spring, MD 31. Date filed (Month, Day, Year)

JAN 3 1 2000 2. Registrar's Signature Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) January 4b. City, Town, or Location of Death 29, 2000 4c. County of Death Earle Cooper WHITE 15:25 4a Facility Neme (If not institution, give street end number) Anne Arundel Medical Center Annapolis Anne Arundel Hours Min. 8. Date of Birth (Month, Dey, Year) Oct. 5, 19 7. Aga (In yrs. lest birthday) 86 Yrs. If Under 1 Year Birthplace (State or Foreign Country) MD 5. Social Sacurity Number 214 05 2241 Months Days 180 M 2□ F Yrs. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Loch Haven 1 ☐ Yes 2K No 10e. Street and Number 3424 South River Terrace 10f. Zip Code 10g. Citizen of What Country? 21037 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - Amarican Indian. 11 Maritel Status Black, White, etc. 1 X Yas 2 No If Yes, Give Yaar or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) stockbroker investment 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Earle Cooper White, Esther Glover Perry 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4032 Cadle Creed Rd., Edgewater, MD 21037 Brian L. White (son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Buriel 2 Cremation 3 ☐ Removel from Stata Metropolitan Crematory 1-31-00 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ling 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 23a. Part1. Enter the disease, or complications that around the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel diseese or condition resulting In death) cancer tastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Metastatic cancer Due to (or as a consequence of): arry thmia 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2/200 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy performed? of death? 2 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA 2 ER/Outpatient 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

P

Completed

Be

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinat mast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examples.

altimore, Maryland 21215-0020

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death

Examiner

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25. Was case referred to medicel examiner? 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stele) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) 29b. Signature and IIIIs of certifier

**Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated 2 Medical Examinar: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and menner steted.

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29c. Licensa number 0055556 MO

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29d. Data signed (Month, Day, Year) 2000

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MO

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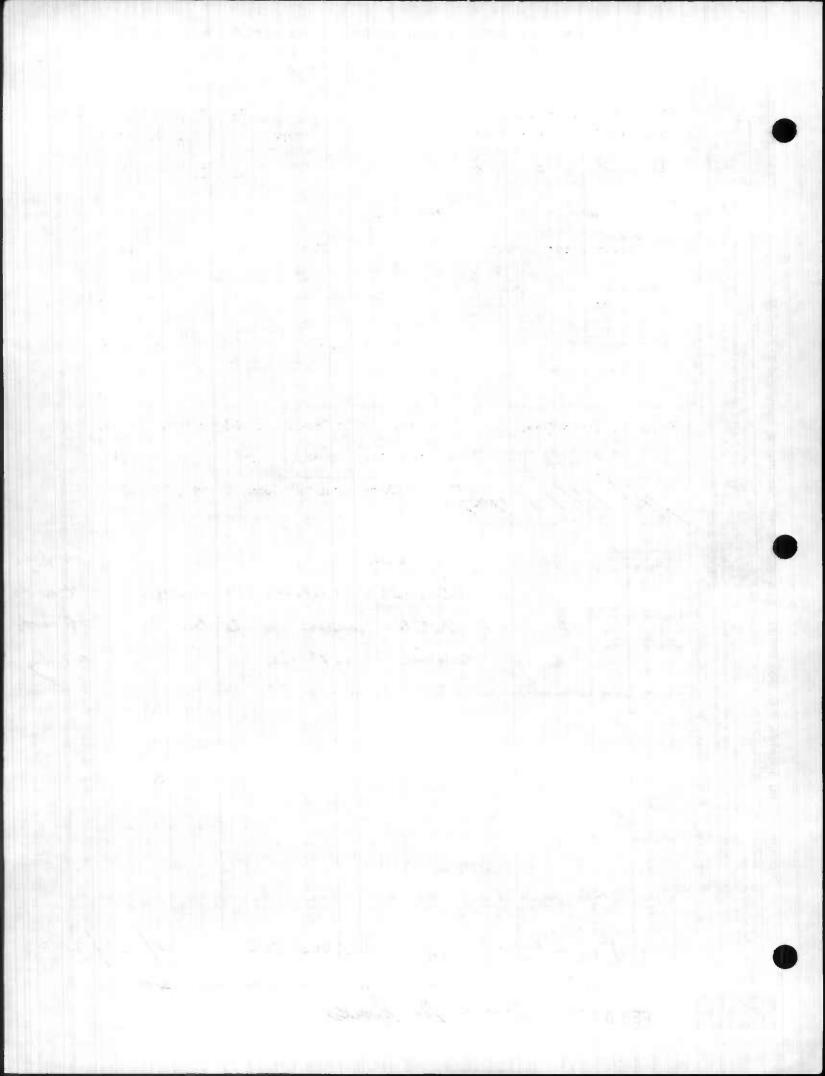
State

Registrar

RIESH 31. Dete filed (Month, Day, Year) FEB 0 4 2000

KUMAR 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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| 29e. Certifier (Check anily and menner as stated. 29e. Certifier (Check anily and menner as stated.) 29e. Certifier (Check anily anily and menner as stated.) 29e. Certifier (Check anily anily anily anily and menner as stated.) 29e. Certifier (Check anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily anily | Š | 25.50 | ertific | d | ould not be etermined | 286. Piece of | njury - At ho etc. (Specify | oma, ferm, // | street, fecto | y, office | | | | ber or Rural | Route Number, |
| 30. Name and address of person who complated cause of deeth (Item 23e) (Type, Print) 600 N. Wolfe St Balhmure MD 21287 State 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture | | Hospitu 1.24 hours Funera ietely fille | | (Check only 2 Me | tifying Phy dical Exam | inar: On the basis | of examine | wledge, de tion end/or | ath occurred Investigetion | at the tir | me, dele end plec opinion, deeth occ | e, and due to the curred et the time | a causa(s) and n , dete and pleca | nenner as sta , and due to | ited. the cause(s) |
| 30. Name and address of person who complated cause of deeth (Item 23e) (Type, Print) 600 N. Wolfe St Balhmure MD 21287 State 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture | | Vithir To th comp | M | 29b. Signetura and 19 a 4 co | ertifier | 0- | | | 29 | c. Licens | se number | - | 29d. Dete sign | ed (Month, D | Pay, Year) |
| 30. Name and address of person who complated cause of deeth (Item 23e) (Type, Print) 600 N. Wolfe St Balhmure MD 21287 State 31. Dete filled (Month, Dey, Year) 32. Registrer's Signeture | | | | 1 1h- | 11 | 10 | 1 | 5 | > | 74 | 2975 | | 110 | 1/20 | nau |
| State 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture | 7 | 20 | | 30. Neme and address of pe | 1 1 | | | | | 129 | 3.7 | | 112 | -1/20 | A |
| | | Sta | ite | | Year) | 32. Regis | strer's Signe | | 1 | , | | | | | |

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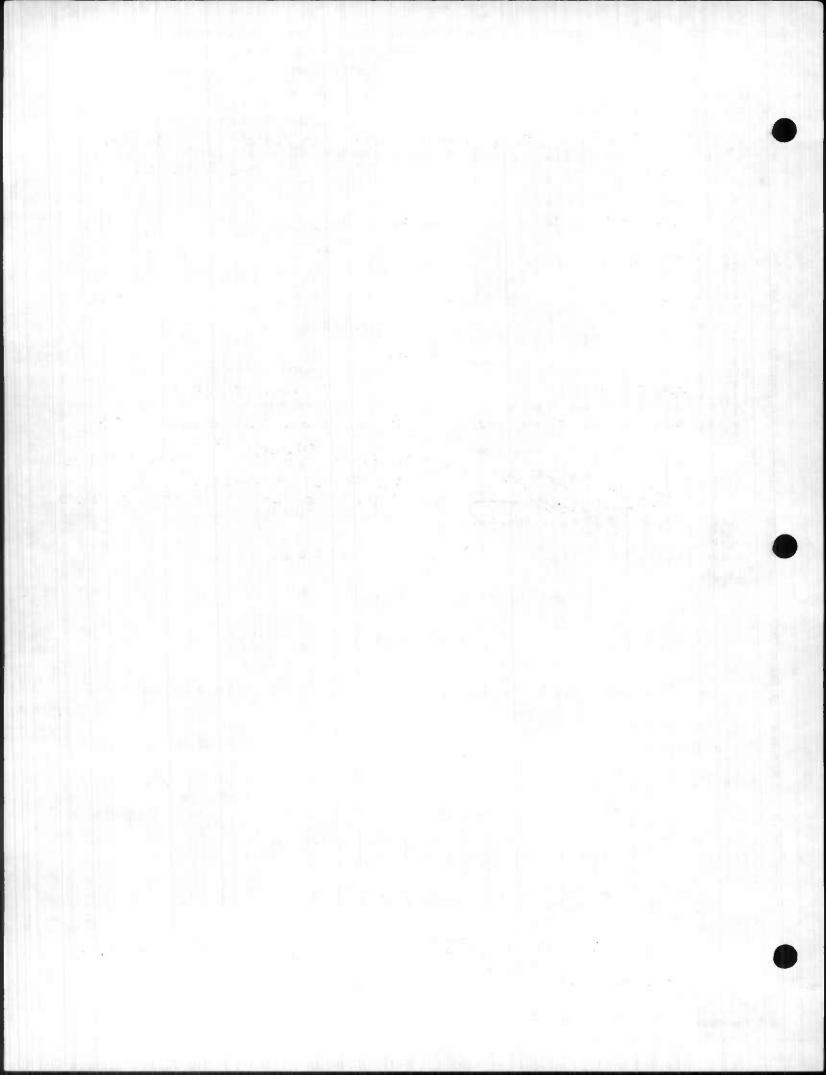
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dele of Death 1. Decedent's Name /First Middle Last) 3. Time of Death Month **Physician** February 7,2000 8:15 a.m. Evelyn Alexander Walker /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, give street and number) Examiner Charles County Nursing Rehab Center La Plata Charles If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** Min February 10 M XX 73 Yrs. 14,1926 Maryland 578-30-6663 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Example must be notified and once. 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince George Brandywine , Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of Whet Country? 20613 U.S.A. Funeral 10505 Cedarville Road 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Ccok Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Silvius John E. Emma Whalen Davis 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sandy Broadwater 14 Fairmont Place, Indian Head, Md. 20640 Daughter 20b. Pleca of Disposition (Neme of cametery, cremetory or other place rebruary 11,2000 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) Metro Funeral Services 21. Signeture of Funeral Service Licenson Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian Head, Md. M00668 23a. Pert1. Enter the second of complete in second of the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart funder. List only one cause on each line. Onset and Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) COLON CANCER Examiner Due to (or es e consequença of Examine physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es a consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequença of). 88 esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably + I winknown þ 24b. Were eulopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed certificate has b lirector, page 2 s 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Year) Certification: 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1-8 Naturel 5 Pending death. 1 Tes 2 No investigetion 2 Accident after deat 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, streel, fectory, office building, etc. (Specify) 281, Location (Street end Number or Rural Route Number, City or Town, Stete) the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction 4 Homicide edicai Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature end title of cartifier 29c. License number 29d. Dele signed (Month, Day, Year) D28352 February 7, 2000 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State

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Registrar

FEB 0 9 2000



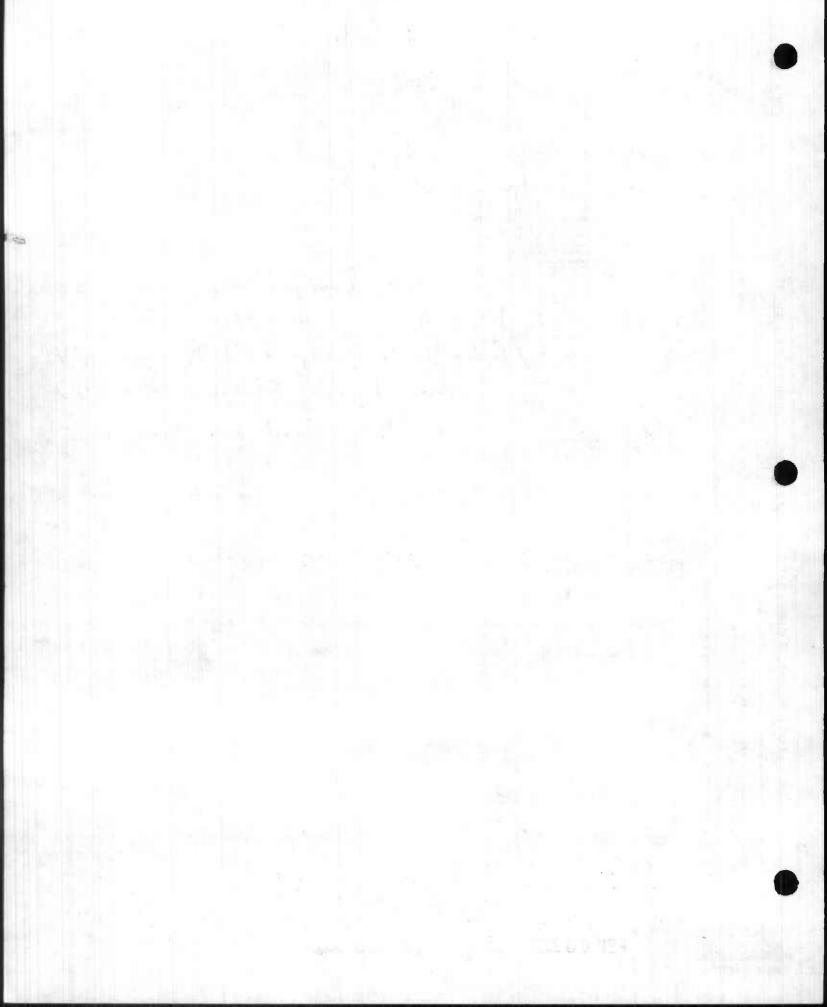
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔒 🗎 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Ph Year **Physician** Wim bush pn DAMIN 7:01 February 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland Inton thern Hospita If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 10M 20 F Months Days Worth 220-26-698 Yrs. Director Usuai Residence of Decedent the Menyland 10b, County 10a State 10c. City, Town or Location 10d. inside City Limits ? Is marked other than "natural", or items 23s or 28s-(show traumstic avent, the Medical Examinar must be notified at 1 TYES 2 No Prince Director MAIZY and Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hyglene.

Int: If Ham 27 Is marked other than "natural", or items 23s or 1552 20613 Wine Completed by Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritei Status Bieck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 malayec 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be harles Hennetta 197/4 26617 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra 15521 Brand 60415 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, State 1 1 Buriai 2 □ Cremetion 3 Removal trom State Department o Important: If any Injury or Cosurrection 4 □ Donation 5 □ Other (Specify) 12 00 22. Name end Address of Facility 21. Signature of Funeral Service Licensee 20108 4 sms 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart tailure. List only one cause on each line. terval Betweenset and Be **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner to (or as a consequence Medical Certification: To Be Completed by Physician/Medical Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the deeth certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or ss a Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use/contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after deeth.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, tarm, street, tactory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pisca, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the of certitier 29d. Date signed (Month, Day, Wear) 2000 30. Name and address of person who completed cause of yeath (Item 23a) (Type, Print) Clinton Berna 7700 012 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State 09 2000 FEB Registrar



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| 71 | N IN | t | |
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| e of Maryland / Department of Health and Me | ntal Hygiene | 05 | 31 | 6 |
|---------------------------------------------|--------------|----|----|---|
| Certificate of Death | See No | 00 | 91 | |

| WI. | LLIAMS |
|--------|-----------|
| | |
| | Physician |
| | /Medical |
|); iii | Examiner |

Ann Williams 4a Facility Nama (If not institution, giva street and number)

1. Decedent's Nama (First, Middla, Last)

FEBRUARY 4b. City. Town, or Location of Death

3. Time of Death 2:10P.M.

10d. Inside City Limits

Funeral

217 OUAKER BOTTOM ROAD 5. Social Security Number

HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) Months Days

3,2000 4c. County of Death HARFORD

1□M 2XF 227-52-7214 Usual Rasidence of Decedent 10b. County

59 10c. City. Town or Location

8. Date of Birth (Month, Day, Year) 07/20/1940 Hours

2. Data of Death

Month

 Birthplace (State or Foreign Country) Virginia

Director

28a-f show must be notified at

ь thems 23a

"natural", or

Hyglens. In other Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of the Transfer of

permit. Pages 1 and 2 should be filled with Department of Health and Mersal Hygen important. If them 27 is married other than any figury or other treatmetic source.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

Examiner

Physician/Medical

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Completed

Be

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Certification:

edical

this After this funaral

To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funara

72 hours after

Baltimore, Maryland 21215-0020

Directo

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Completed

Be

MD Harford 10e. Street and Number

Havre de Grace

1 Yes 2 No 10g. Citizen of What Country?

Year

10a. Stata

217 Quaker Bottom Road 12. Was Decedent Evar in U,S. Armed Forces?

1 Yas 2 No

21078 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian. Black, Whita, etc. Specify: White

1 Navar Married 2 Married 3 XWidowed 4 ☐ Divorced

If Yas, Giva Yaar or Datas: 15. Decedent's Education (Specify only highast grada completed)

College (1-4or 5+)

5+ years

16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired)

1 ☐ Yes 2 No Specify:

10f. Zip Code

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 17. Fathar's Nama (First, Middla, Last)

Homemaker

Home 18. Mother's Name (First, Middle, Maiden Sumama)

USA

George Taylor

19a. Informent's Name/Ralationship (Type, Print)

Marguerite Bryant 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Daniel Williams- Son

4401 Little Ridge Ln., Chesterfield, VA 23832 20b. Place of Disposition (Nama of cematary, crematory or other place)

20c. Location - City or Town, Stata

20a. Mathod of Disposition

1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify)

Elmwood Cemetery 22. Nama and Addrass of Fecility

2/8/00 Norfolk, Virginia

21. Signature of Funaral Sarvice Licensee

Mitchell-Smith Funeral Home, P.A. 23a. Rart). Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death

fmmedieta Ceusa (Final diaaasa or condition rasulting in death)

gunshot wound of head Contact

Sequantially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disaase or Injury that initiated evants rasulting in daath) Last

Due to (or as a consequence of): Dua to (or as a consequence of):

23h. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown

Bipolar Depression

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.

24a. Was an autopsy performed? Limited

24b. Ware autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1.2 Yaa 2□No 26. Place of Death (Check only one)

25. Was casa refarred to medical examinar? TXXYas 2 No 27. Mannar of Death

1 Natural

2 Accidant

3/X Suicida 4 Homicida

28a. Deta of Injury (Month, Day Year) Fein (2 2-3-2000 5 Pending invastigation

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of fnjury untrown

Other: 4 Nursing Home XX Rasidence 8 Other (Specify) 28c. Injury at Work? 1 Yas 2 No

28d. Describe how injury occurred

28a. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Subject Shet Self
281 Location (Street and Number or Rural Route Number,
City or Town, State) 217 Queter Bottom

29a. Certifler (Check only Residence

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

**CXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

29b. Signatura and titla of certifian

O.C.M.E.

FEBRUARY 4,2000

30. Nama and address of person who completed causa of death (Item) (Type, Print)

Radentz

111 Penn Street, Baltimore, Maryland 21201

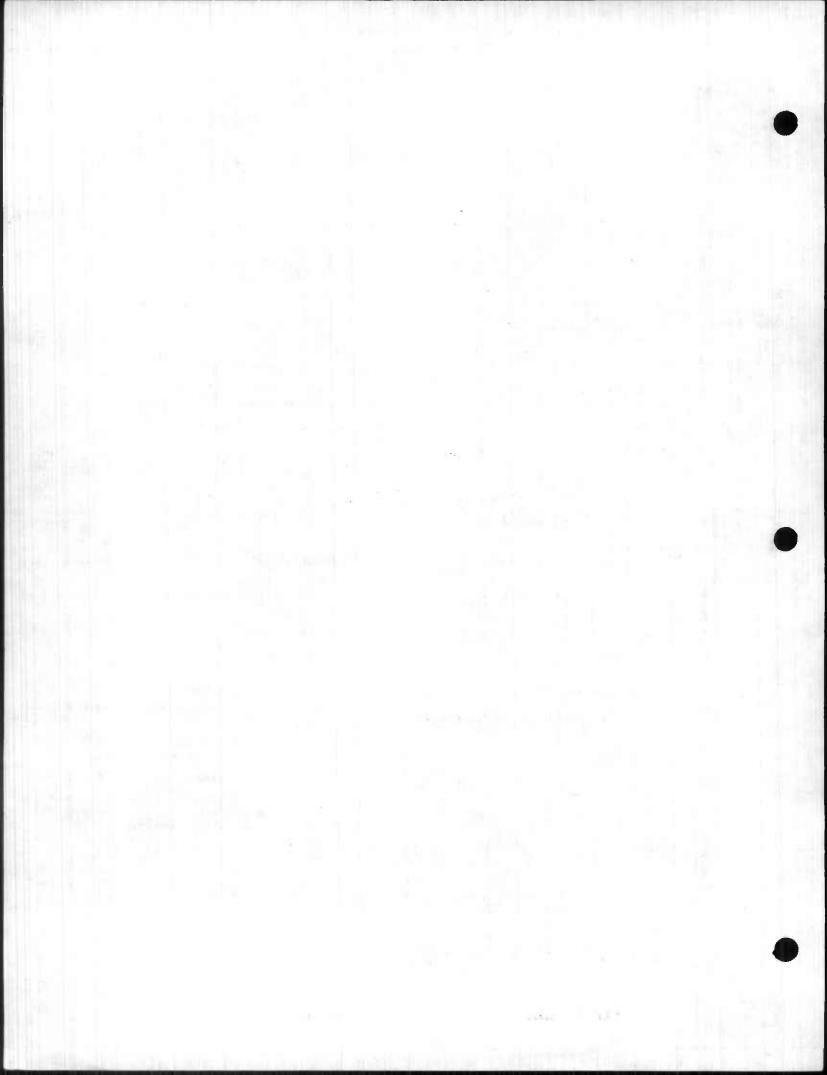
State Registrar

Stephen S 31. Data filed (Month, Day, Year) 5. FEB 7

6 Could not be determined

32. Registrar's Signature Denew

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 2000 Margaret Gibson Wilson Feb. 8:20am 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1□ M 2X F 212-05-0308 95 09/15/1904 Maryland Uaual Rasidence of Dacedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 ☐ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 631 Ontario Street 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 Never Married 2 Merried 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elamentery/Secondery (0-12) College (1-4or 5+) Chief Operator Phone Company unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumame) Bertie Whitcomb Hugh Boyd Gibson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 631 Ontario St., Havre de Grace, MD 21078 Paul Armstrong 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cramation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2/8/00 Havre de Grace, MD Angel Hill Cemetery 21. Signetura of Funarel Sarvice Licensee 22. Name and Address of Fecility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a. Per(1. Enter the disasse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Cause (Final disease or condition rasulting in death) Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Dua to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown tupeniension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Emosderatic andrivingular DIFFARE 1 Yes 2 NO No 1 Yes 2 No 25. Was case rafarred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Menger of Death 28d. Describe how Injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending Invastigation 1 Natural 1 TYes 2 TNo 2 Accident 6 Could not be datarmined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

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29b. Signature and title of certifier

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Baltimore,

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State Registrar

of person who completed cause of death (Itam 23a) (Type, Print) 30. Name end address

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32. Registrar's Signeture 2000

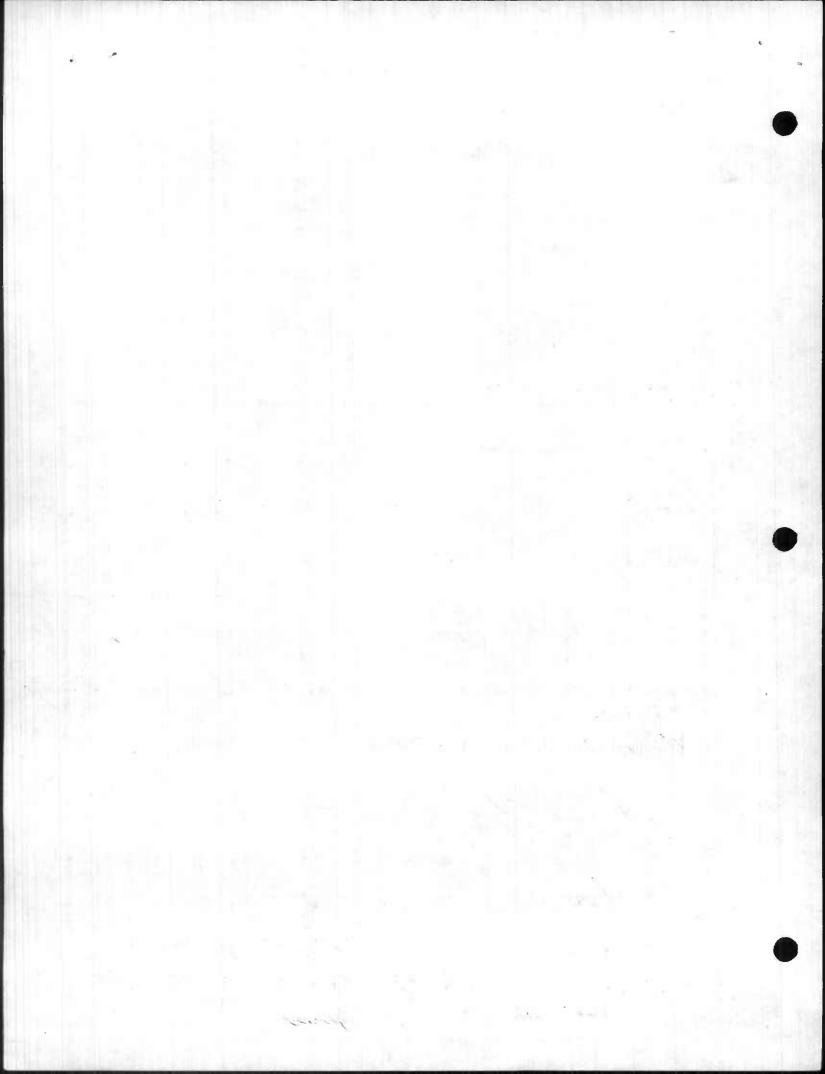
1 Certifying Phyalcian: To tha best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated.

2 Medicat Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

6Mus

29d. Data signed (Month, Day, Year) 2000



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

05318 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 31, 2000 **Physician** 1745 Verlon Cleveland Wright /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Undar 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Deta of Birth (Month, Day, Year) **Funeral** Min 1 M 2 □ F Months Days Hours 69 Yrs. 213-28-6240 Director Jan. 21, 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Directo MD 28a-1 Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? b 238 4041 Gravel Hill Road 21078 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married b Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ filed within 72 hours 3 ☐ Widowed 4 ☑ Divorced Yaar or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Self employed Plastering Contractor 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Nama (First, Middle, Last) Pages 1 and 2 should be fall mant of Health and Mental H lant; If them 27 is marked oth Cleveland James Wright Bricie Etta Cullum t9a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Mrs. E. Danies Brown (Daughter) 623 Arch St., Perryville, MD 21903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State HD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Rock Run Cemetery 2/5/00 Havre de Grace, MD 21. Signature of Feneral Service Licenses 22. Name and Address of Fecility Tarring-Cargo Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner lew requires that the death certificate be executed use as the buriel-transi Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury Due to (or as a consequence ot) the attending physician Physician/Medical that initiated evants resulting in death) Last Dua to (or as a consequenca of): be detached for use Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown Be Completed by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No that or Attending Physician: The safer deeth.

al Director: After this certificated in by the funeral director, put 25. Was casa referred to medical examiner? 26. Place of Death (Check only ona) Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2N No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Sulcide 28e. Placa of Injury - At homa, farm, street, tactory, office building, etc. (Specify) 4 | Homicida To the Hospital
within 24 hours a
To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely Medicat Examiner: On the basis of examiner and mannar stated. (Check only one) 29b. Signature and title of cartifier 29d. Data signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print 10

31. Data filed (Month. State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Vesi 24 2000 7:42am Freeman Monroe Williams Jan. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 217 Quaker Bottom Road 5. Social Security Number 6. Sex 7 Havre de Grace Harford If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) If Under 1 Year 8. Date of Birth (Month, Dev. Year) 1**X** M 2□ F Months Deys Yrs. PA 74 07/14/1925 132-14-5161 Usuel Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 1 ☐ Yes 2 No Harford Havre de Grace 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 217 Quaker Bottom Road USA 21078 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Yeer or Dates: 1 Never Merried 2X Married 1 Yas 2 No Specify: Specify: White WW2 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Department Store Advertising/Sales 4 years 18. Mothar's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Esther Brundage Cass Monroe Williams 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Ann Williams- Wife P.O. Box 189, Havre de Grace, MD 21078 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, State 1X Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 Donation 5 Other (Specify) Elmwood Cemetery 1/27/00 Norfolk, VA 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 21. Signeture of Funeral Service Licenses Jaine 123 S. Washington, Havre de Grace, MD 21078 23a. art Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel ASCUD disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Disaase or Injury that Initieted evants resulting in deeth) Lest Due to (or es a consequença of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was en eutopsy 1 Yes 2 No 1 TYes 2 TKNo

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29b. Signature and title of cartifier

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours effer or Department of Heelth and Mental Hygiene. Important: If fem 27 is merked other than "naturel", or flee eny Injury or other treumetic event. Its increases

Baltimore, Maryland 21215-0020

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hysician and the buriel-transit certificate be executed physician USB 85 1 signed by the e Division of Vital Records, P.O. peeu certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral completely filled in by

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State Registrar 25. Was casa referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Dev Year) 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Time of 5 Pending investigation 1 Neturai 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29c. License number

> JAN 24, 2000 OCME

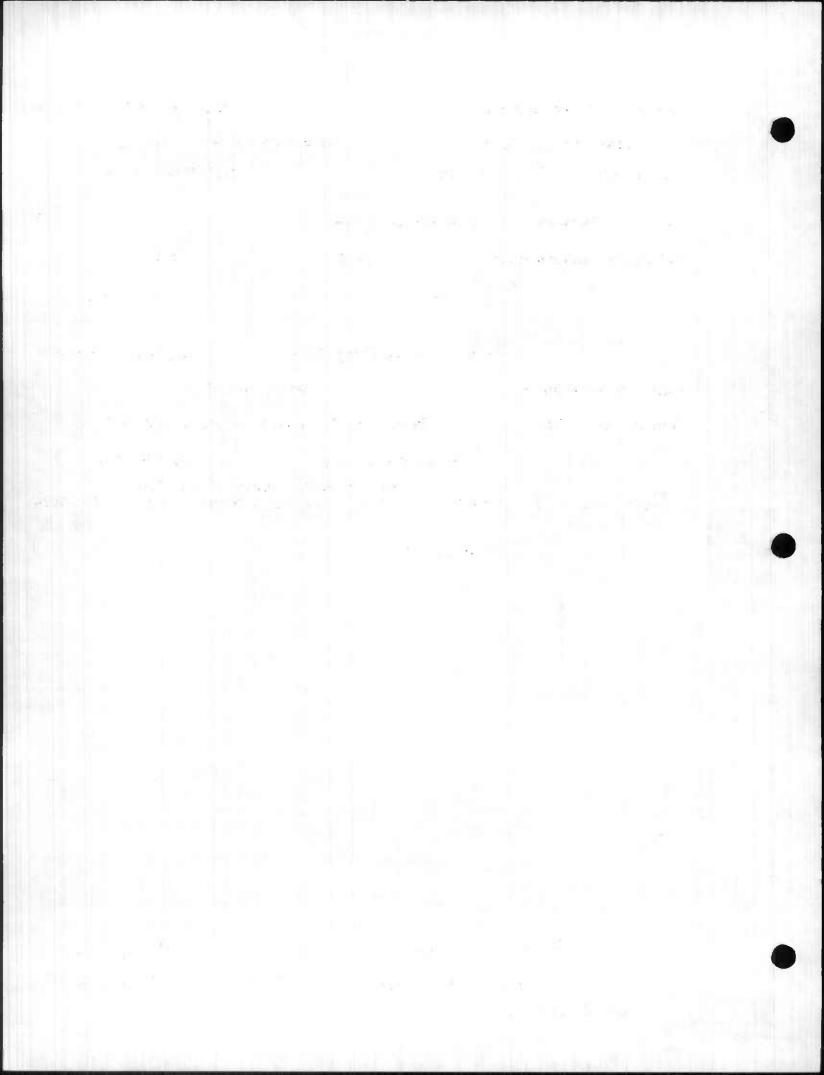
30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print)

BELTIN MD 21014 410-879-6564 BEZAM QD

32. Registrer's Signature

DME

31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend item 20b HCHD 1/27/2000 Certificate of Death

2. Date of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

HOURS

WEEKS

29d Date signed (Month, Day, Year)

30MINUTE

1 ☐ Yes 2 No

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

Funeral Director ahos

the Maryland r 28a-f show b must be Berns 23a "natural", or Ita-dical Examinar 72 hours after filed within 7 Hygiene. other than "n Pages 1 and 2 should be nent of Health and Mental Department of Health and important: if Item 27 is m any injury or other traum 2008.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the burial-transit that the death certificate be assecuted should page 2 s this Certification: After or Attending death.

Box 68760 P.O. Records. Division of Vital To the Hospital or Attendition within 24 hours after death.
To the Funeral Director; A completely filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in

10a. State Maryland Director 10e. Street and Number Funeral by Completed Be Clarke 20a. Method of Disposition Immediate Cause (Fine) disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical ð Completed Be OL

19,2000 09:00 AM JANUARY BILLY WILKINSON EUGENE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Baltimore Towson 8. Date of Birth (Month, Day, Year) NOV . 11, 1934 If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Montha Days Hours **№** M 2□ F 65 314-32-2569 Indiana Usual Residence of Decedent 10b. County 10c. City, Town or Location Harford Street 10f. Zip Code 10g. Citizen of What Country? 3748 Peach Orchard Road 21154 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1. ☐ Yea 2 ☐ No ff Yes, Give Was Decedenl of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 25 Married Specify. White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Datea: Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Survey Engineering 17. Father's Neme /First Middle Last 18. Mother's Name (First, Middle, Maiden Sumame) Wilkinson Howerton Nancy Alberta Wallace 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy R. Wilkinson/wife 3748 Peach Orchard Road, Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1-27-080 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Zion United Methodist BelAir, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses Mucal 50 W. Broadway Street, Bel Air, Maryland 21014 23a. Part. Eigher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cruses on each line. ASYSTOLIC ARREST Due to (or as a consequence of) HYPOXEMIA INTERMITTENTLY Due to (or as a consequence of): FIBROCYSTIC AND INTERSTITIAL LUNG DISEASE Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Vas 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE 24a. Waa an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? 25. Was case referred to medicat examiner? 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 TYes 2 □ No **Q** □ Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29c. License number 29b. Signature and 55453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA BARR, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

State Registrar

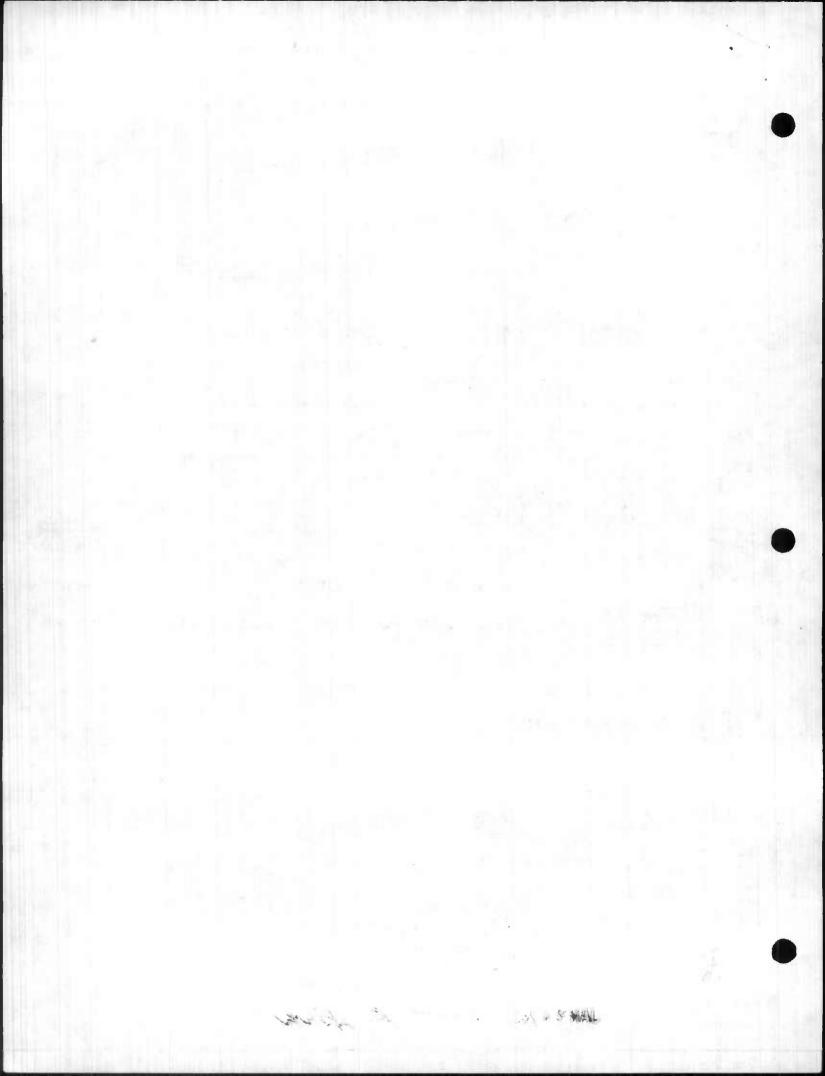
Medical

29a. Certifier

(Check only

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.

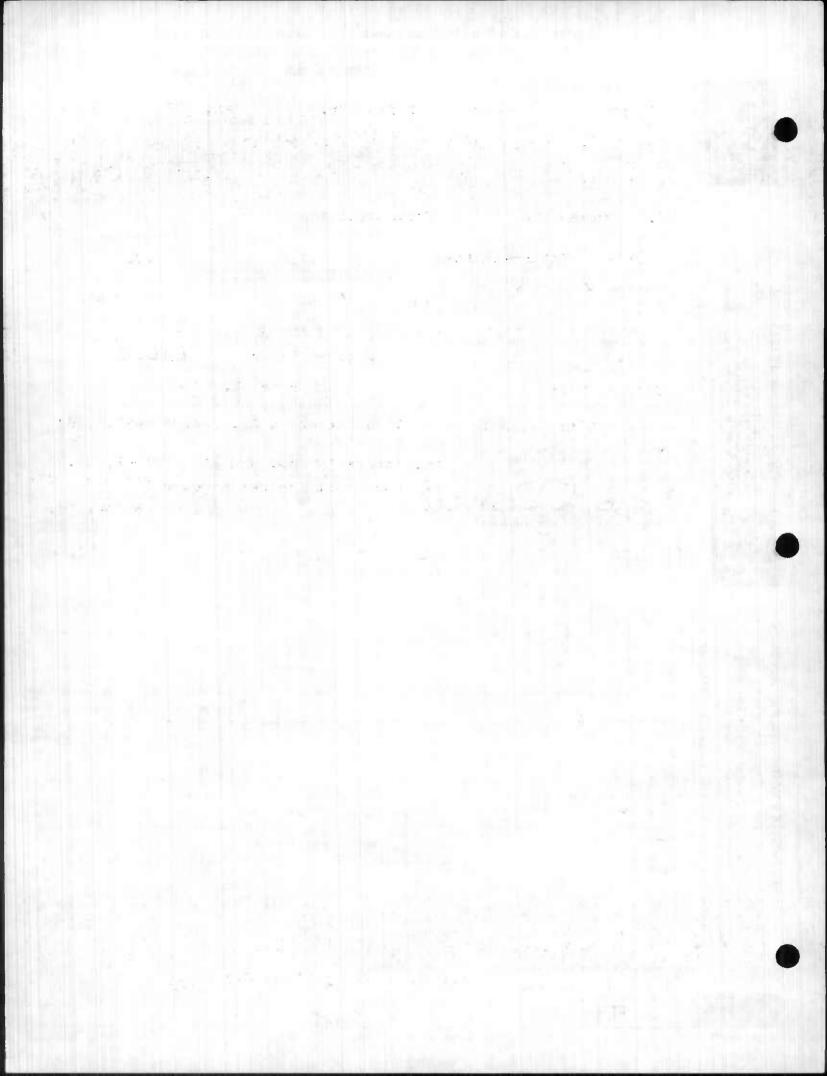
2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 3

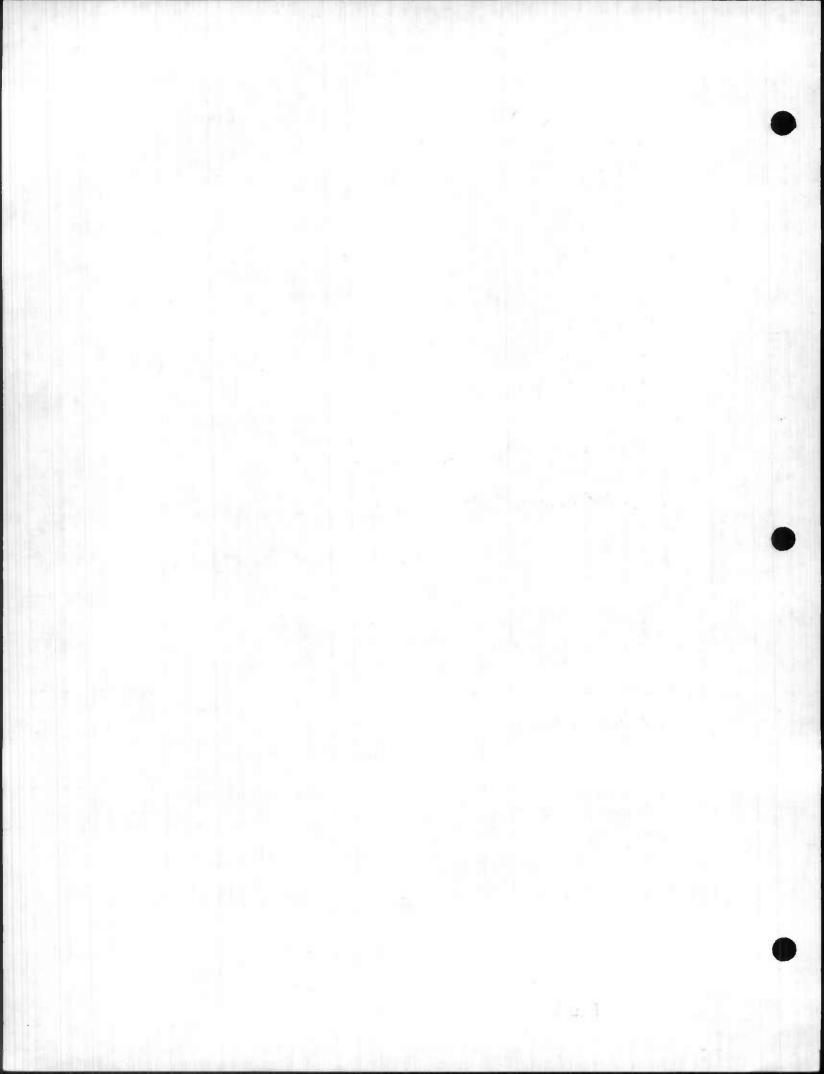
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| Physician /Medical | Robe | | Henr | OHE . | White | Sr | 4b. City, Town, or | Jan. | 21 2 | 000 1 | 0:40P | |
| Examiner | | | ursing H | | | 1 | Annapol | is | Anne | Arund | e1 | |
| Funeral | 5. Social Security N | | | e (In yrs. lest birt | | der 1 Year | If Under 24 Hrs | 8 Dete of Birt | h | | (Stete or Foreign | |
| Director | 5. Social Security Number 6. Sex 12 M 2 F 6. Sex 13 M 2 F 6. Sex 14 Months Days Hours Min. 1. Age (In yrs. lest birthday) 1 Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. 1. Age (In yrs. lest birthday) 1 Under 1 Year 1 Under 24 Hrs. Month, Day, Year) 1 Under 1 Year 1 Under 24 Hrs. Month, Day, Year) 1 Under 1 Year 1 Under 24 Hrs. Month, Day, Year) 1 Under 1 Year 1 Under 24 Hrs. Month, Day, Year) 1 Under 1 Year 1 Under 24 Hrs. Month, Day, Year) 1 Under 1 Year 1 Under 24 Hrs. Month, Day, Year) 1 Under 1 Year 1 Under 24 Hrs. Month, Day, Year) 1 Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 1 Year 1 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Under 2 Un | | | | | | | | | | giniA | |
| /land | 10a. State 10b. County 10c. City, Town or Location 10d. | | | | | | | | | | Inside City Limits | |
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| ath with the Marylan 23s or 28s-f show ust be notified at ral Director | 10e. Street and Nu | mber | | | 10f. 2 | Zip Code | | | 10g. Citizen of V | What Country? | | |
| th will | 172 | 6 Bat | tsneck | Road | | | 21666 | | U.S | 5. | | |
| frer death v | 11. Marital Status | | 12. Was Decedent Armed Forces? | Ever in U,S. | 13. Was De | cedent of I | Hispanic Origin? (S en, Mexican, Puer | Specify Yes or No | 14, Rac | e - American I | ndian, | |
| 0 0 5 | | led 2 Married 4 □ Divorced | 1 Yes 2 | | | | Specify: | to rinari, dio.y | | Blac | k | |
| n 72 hours naturel', ed cal Eve | | 15. Decedent's Ed | ucation | | Decedent's U: | sual Occu | pation | | 16b. Kind of Bi | usiness/Indust | ry | |
| 도 '. 의 궁 | (Spec | offy only highest gradent (0-12) | de completed) College (1-4or : | 54) | (Give kind of life. DO NOT | work done Tuse retire | during most of wo d) | rking | | | | |
| filed within Hygiene. ther than ent, the Me | 1 1 | indaty (0-12) | College (1-40) | 54, | Aı | uto | Mechani | C | LAGO | R | | |
| = T + E e | 17. Fether's Name | (First, Middle, Last) | | me (First, Middle, | | | | | | | | |
| | Eugen | Eugene White Rose Washington | | | | | | | | | | |
| d 2 should h end Men 7 le marke treumatic | 19a. Informant's N | ame/Reletionship (7 | ype, Print) | 19b. | Malling Addre | ess (Stree | t and Number or R | ural Route Numbe | er, City or Town, | State, Zip Co. | de) | |
| 4439 | Audrey | White | (wife) | | 1726 | Bat | tsneck | Rd. St | evens | ville, | Md | |
| of Heell of Heell I Nem 2 r other | 20e. Method of Dis | position | Dames of the Chate | cometer | Disposition (/ | Vame of or other pla | ice) | Date | 20c. Location - | City or Town, | Stete | |
| | | 5 Other (Specify | Removal from State) | Md. | Vete | rant | s Cem. | 2-1-200h | Hurlo | ock, M | id. | |
| permit. Peg Department Important: I eny Injury o pace. | 21. Signature of Fu | neral Service Licen | 90 | 1 | 22. Name | and Addr | ess of Fecility | | 3 : | 22 Eas | t Ave. | |
| FEE | D 00. | 2 | 120 | .0// | Das | hiel | l Funer | al Serv | rice | | | |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| Physician | shock, or heart failure. List only one cause on each line. Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval | | | | | | | | | | | |
| /Medical | Immediate Ceuse (Finel disease or condition resulting in death) e. Due to (or as a consequence of): | | | | | | | | | | IM | |
| Exam i ner | | | | | | | | | | | | |
| خ السو | Due to (or as a consequenca of): | | | | | | | | | | | |
| ifficete be executed graphysician end es the buriel-trensit | Sequentially list on | | | | | | | | | | | |
| EX. | Sequentially list conditions, If eny, leading to immediate cause. Enter Undertying Cause (Disease or injury c | | | | | | | | | | | |
| physicians the burners the burners as the burners and the burners are the burners and the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burners are the burn | (nat miliated events | | C | Due to (or as e c | onsequence o | of): | | | | | | |
| | resulting in death) Last | | | | | | | | | | | |
| deeth cer e ettendir od for use | d | | | | | | | | | 1 | | |
| sicia | Part It. Other signif | icant conditions co | entributing to death b | out not resulting in | the underlying | g cause gi | ven in Part I. | 23b. Did | lobacco use co | ntribute to the | e cause of death | |
| that the deem cent led by the ettending deteched for use a | | | | | | | | | Yes 2 No | 3 Probabi | fy 4 Unknow | |
| be de de de de de de de de de de de de de | | | | | | | | | | 1 | | |
| | | | | | | | | | an autopsy | avallat | autopsy findings ble prior to | |
| tate has been s pege 2 should | | | | | | | | | | of dea | etion of cause th? | |
| ate has bege 2 s | | | | | | | | 10 | Yes 25 No | 1 🗆 Ye | es 2 No | |
| certificate rector, per Be Co | 25. Was case refer | red to medical | | | | | 26. Place of De | ath (Check only o | one) | | | |
| | examiner? | No | Hospital: | ent 2 ER/Ou | tpatient 3 | DOA OI | her: Nursing | Home 5 Resi | dence 6 Oth | ner (Specify) | | |
| erthis heral d | 27. Manner of Deat | | 28a. Date of Inju | ıry. 28b. T | ime of | 28c. Inju | iry at | 28d. Describe how injury occurred | | | | |
| death. ctor: After y the fune fication | 2 Accident | 5 Pending investigation | (MOND), DO | ly roury | M | | Yes 2□No | | | | | |
| | 3 Suicide 4 Homicide | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To the Hospital or J within 24 hours after To the Funeral Dire completely filled in b Medical Certi | 29a, Certifier (Check only | Certifying Phy | reician: To the best fner: On the besis o | of my knowledge | , death occurre | ed at the ti | ime, date end plac | e, and due to the | cause(s) and m | anner as state | d. | |
| in 24 hours the Funer spletely fill | one) | | and manner st | | | | | at the time, | | | | |
| With To the | 29b. Signature and | vitle of certifier | | | | | se number | | 29d. Dete signe | | r, Year) | |
| | | 1 400 | Comme | | | D | 37036 | | | 02/40 | | |
| | 30. Name and addr | ess of person who | completed cause of c | | Type, Print) | 1 | Chi.La | .00 | | | | |
| | Gan | J' Spra | se 210 | DR 17. DO | voil 1. | Ime | Chite. | NID 21 | 619 | | | |
| State | 31. Date filed (Mon | | | rar's Signature | 1. | · · | | | | | | |
| | | FR 0 9 20 | 170 I N 730 | 211 1 Part of | 19 | / | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** JOHN FRANCIS WILLIAMS. 2000 /Medical Feb 10:25PM 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner Memorial Hospital at Easton Talbot Easton
It Under 24 Hrs H Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1X M 2 F 81 214-16-4258 Director APR.23,1918 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD TALBOT 1 ☐ Yes 2 ♥ No CORDOVA Director 28a-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 32646 HIDDEN ACRES ROAD Berns 23s 21625 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ∑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married illiams, John Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) -0-FARMER AGRICULTURE 17 Father's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 JOHN MALIN WILLIAMS LEOTA GANNON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health in Important: If Item 27 is any Injury or other tra price. MURIEL C. WILLIAMS/ WIFE 32646 HIDDEN ACRES ROAD, CORDOVA, MD 21625 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Removal from State WOODLAWN MEMORIAL PARK 2-5-00 4 ☐ Donation 5 ☐ Othar (Specify) EASTON, MD 21601 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Ceuse (Finel disease or condition resulting In deeth) Myocandon Julancton /Medical MONTH Examiner Examiner MANDENT physician and the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 1880 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 11 Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 DAM 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Impatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 DNatural 5 Panding 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu Investigation death. 2 Accident 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) Feb Heemk 053236 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) BRUCE HELMLY, 403 MARVEL M.D. COURT, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 3 2000 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G781 3/13/00 yo Certificate of Death 2. Data of Death 1. Decedent'a Name (First, Middle, Last) 3. Time of Death Month **Physician** Ernest Gladstone Wadsworth, Jr. February 5,2000 6:00PM /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 9335 Maranatha Place Nanjemoy Charles If Undar 1 Yaar | If Undar 24 Hrs. | Months Days Hours Min. 5. Social Security Number 083-36-1046 Birthplaca (Steta or Foraign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1 2 F 54 Yrs. **Director** AUGUST 31, 1945 NEW YORK Usual Rasidanca of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 □ Yas 3 No MARYLAND CHARLES NANJEMOY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda with than "naturel", or items 23s or the Medical Examiner must be a 9335 MARANATHA PLACE 20662 U.S.A. death v Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 Ø No It Yes, Giva Year or Dates: 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispenic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Itam 27 Ia marked other than "naturel", or Itam eny Injury or other traumatic avent, the Medical Examination. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 4 SALES AGENT INSURANCE 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) ERNEST G. WADSWORTH, SR. GRACE MILNE JONES 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) DONNA L. WADSWORTH/WIFE 9335 MARANATHA PLACE, NANJEMOY, MARYLAND 20662 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 D Burial Cramation 3 Ramoval from Stata 5 Other (Specify) 4 Donat THE HUNTT CREMATORY 2/7/2000 WALDORF, MARYLAND 21. Signatury & Fungeti Service Lighton 22. Nama and Addrass of Facility
THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX BROHAWN JPK G. M00053 153, WALDORF, MARYLAND 20604-0153 23a. Pert1. Enfer the disease, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaase or condition rasulting in daath) /Medical Colon Cancer **Examiner** Due to (or es a consequence of): Examiner physician and the burial-transit tha daath cartificata be axecuted Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disaase or Injury that initiated evants rasulting in daath) Last Dua to (or as a consaguance of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): SS usa 23b. Did tobacco use contribute to the cause of deeth? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed paga 2 cartificata has 1 ☐ Yas 2 ☐ No 1 Yes YNO 25. Wes casa raterred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 ☐ Nursing Homa 5 🗶 🎇 sidance 6 ☐ Other (Specify) 1 Yas 2XXo 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Aftar 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Division of Vital or Attending Physician: death. after death Director: filled in by 24 hours a Hospital complataly To the You the I

Registrar

2 Medical Examinar: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licansa number

Certifying Physician; To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

D28352

February 7, 2000

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print)

Krishan Mathur, MD., p.O. Box 1703, La Plata, MD 20646

31. Data filed (Month, Dey, Year) FEB 0 8 2000

29b. Signatura and litla of cartifiar

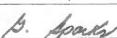
4 Homicida

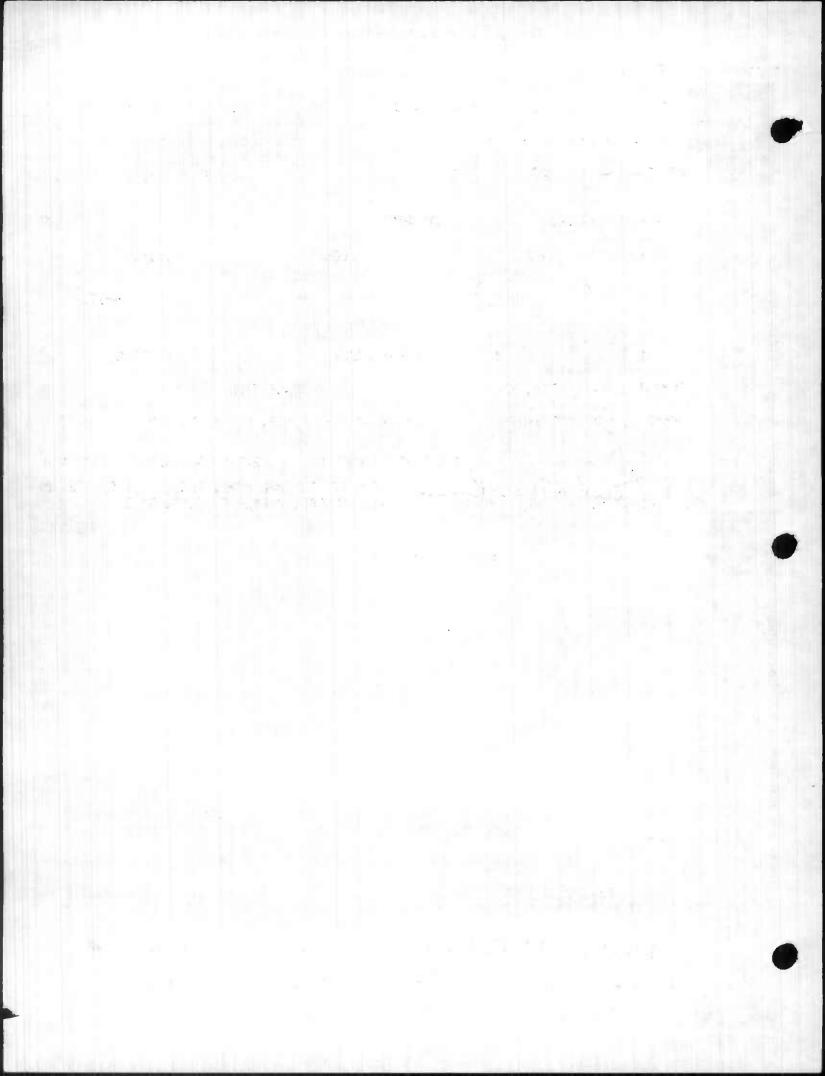
(Check only one)

29a. Cartifier

Medical

32. Registrar's Signatura





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | State (| n waiyiai | | ertificate o | nealth and f Death | wentar m | Reg. No. | 0 (| 35321. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------|----------------------------|--------------------------------|----------------------------------------|--------------------------------------------|-------------------|-------------------|-------------------|--------------------------------------------------|
| | 111 | 1. Decedent's Neme | e (First, Midd | e, Last) | | | | | 2. Date of D | eath | wit. | 3. Time of Death |
| Physici /Medic | | Elizabe | th Phi | anna aka | BUSSARI | WILL: | IAMS | | Feb. | 1 200 | Year 00 | 2:10 a.m. |
| Examin | | 4e. Facility Neme (If | f not institution | n, <i>give street</i> and nu | m <i>ber</i>) | | | 4b. City, Town, or | r Location of Dee | th 4c. County | of Death | |
| | | | | ursing Ho | | | | William | | Washi | 0 | |
| Funeral | | 5. Social Security No | | 6. Sex 1 ☐ M 2 💢 F | 7. Age (In yrs. | last birthday Yrs. | Months Day | | n. (Month, D | irth ay, Year) | | place (State or Foreign |
| Director | | 219-20-1 Usual Residence of | | | 86 | | | | Oct 30 | 1913 | Mary | land |
| death with the Maryland ms 23s or 28s-f show creat be notified at neral Director | | 10a. State | | | 10d. Inside C | | | | | | | |
| n the Maryland r 28a-f ahow Incoffied at | Director | Maryland Washington Hagerstown | | | | | | | | | | 1 ☐ Yes 2 No |
| with th | | 10e. Street and Num | | | | | 10f. Zip Code | | | 10g. Citizen of V | Vhat Coun | ntry? |
| eath w | eral | 17307 C1 | Loverle | | edent Ever in U | S 13 | | 1740 | Specify Vec or N | U.S. | | can Indian, |
| fter dea | Funeral | 1 Never Marrie | ed 2 📉 Man | Armed F | orces? | ,,5. | | f Hispanic Origin? (iban, Mexican, Pue | rto Rican, etc.) | Biac | k, White, | |
| el', o | by | 1 Never Married 2 Married 1 Yes 2 1 If Yes, Give Year or Detes: | | | | | 1□ Yes 2□XN | o Specify: | | Specify | Wh | ite |
| 72 ho natur | Completed | (Speci | 15. Deceden | t's Education st grade completed) | | 18a. Dece | edent's Usual Occ | upetion e during most of w | prkina | 16b. Kind of Bu | usiness/inc | dustry |
| within | mpl | Elementary/Secon | | | 1-4or 5+) | life. | DO NOT use reti | red) | | | | |
| Hygie ther t | Co | 17. Father's Name (| First, Middle. | Last) | | | Homema | | ama (First Middle | Her ow | | ne |
| id be ental ked o | To Be | John M. | | , | | | | 100 | M. Mart | | •/ | |
| shou and M umer | - | 19a. Informant's Na | | hlp (Type, Print) | | 19b. Mail | ing Addrass (Stre | et and Number or F | | | State, Zip | Code) |
| and 2 salth a n 27 le | | V. Harol | Ld Will | iams - Hu | ısband | 173 | 07 Clove | rleaf Roa | ad Hage | rstown, l | Md. 2 | 21740 |
| of He | | 20e. Method of Disp | | 3 ☐Removel from | | Place of Disp cemetery, cre | osition (Name of ematory or other p | lace) | Dete | 20c. Location - | City or To | own, State |
| tmen tant: tant: | | 4 ☐ Donation | 5 Other (S | pecify) | | | 11 Cemet | | | | | , Maryland |
| permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or ite any Injury or other traumatic avent, the Medical Examina 2068. | | 21. Signature of Fur | neral Service | Licensee | H. | // | 2. Name end Add | L | | Funeral : | | 1 017/0 |
| | | 23a. Pert1. Enter th | ne disease or | complications that | CASHO dad | - / | | | _ | | Mary | yland 21740 Approximata |
| Physician | | shock, or hear | rt tailure. List | only one cause on | each line. | in. Do nor an | net the mode of c | ying, such as caron | ac or respiratory | arrest, | | Interval Between Onset and Death |
| /Medical | | Immediate Cause (Final disease or condition | | | | | | | | | | 48 hours |
| Examiner | | Dua to (or as a consequence of): | | | | | | | | | | 10 110017 |
| be sit | Examiner | | | b | | | | | | | i | |
| The law requires that the death certificate be executed ate has been signed by the attanding physician and page 2 should be detached for use as the bunat-Iransit | xan | Sequentially list conditions, first any, leading to immediate cause. Enter Undarlying Cause (Disease or injury c. | | | | | | | | | | |
| e be e | edical | | | | | | | | | | | |
| ng phy as th | _ | | | | | | | | | | | |
| leath certifi attanding d for use as | Physician/N | d | | | | | | | | | | |
| the a | ysic | Part II. Other signific | cant condition | na contributing to d | eath but not res | ulting In the | underlying cause | given in Part I. | 23b. Did | tobecco use cor | ntribute to | o the cause of death? |
| uires that the dea | Y P | Progressive Senile Dementia. Anorexia q Cachexia. 1 Yes 2 INO 24a. Was an autopsy parformed? | | | | | | | | 3 Prol | bably 4 ☐ Unknown | |
| n sign | kq pa | 1 | | 1 | 1 . | | | | | s an autopsy | 24b. W | ere autopsy tindings |
| s been si | plete | Hnor-e | XIA | 9 Ca | chexi | 9. | | | pari | ormed? | COI | ellebla prior to impletion of cause death? |
| sicolor, The law sirector, page 2 s | Completed | | | • | | | | | 10 | Yes 25 No | | ☐Yes 2☐ No |
| | Be C | 25. Was casa reterre | ed to medical | | | | | 26. Plece of De | eath (Check only | one) | | |
| hysic his ce al dire | 2 | 1 Yes 2 1 | | | | ER/Outpatie | nt 3LI DOA | | 7 | idenca 6 Oth | | у) |
| Ing P | :lon: | 27. Manner ot Death 1 Death | 5 Pendin | 9 | ot Injury th, Day Year) | 28b. Time o Injury | W | ury at ork? □ Yes 2 □ No | 28d. Dascribe | how injury occurr | ed | |
| daati ctor: y the | flcat | 2 ☐ Accidant 3 ☐ Suicide | investig 6 Could detarm | not be Geo Blood | of Injury - At h | ome, tarm, st | reet, tactory, offic | | 28t. Location | (Street and Numb | er or Rure | al Route Number. |
| To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director, | Certification: | 4 Homicida | detailli | build | ing, etc. (Specil | <i>y</i>) | , | - | City or To | wn, State) | | 3 |
| ospitu I houri unere | | 29a. Certifiar (Check only | 12 Cartifyin | g Physician: To the Examinar: On the b | best of my kno | wiedge, deat | h occurred at tha | tima, data and plac | e, and due to the | cause(s) and ma | nner as s | tated. |
| the H hin 24 the F nplete | Medical | one) | | and man | nar stated. | Illori arid/or ir | | | anii eni ja penu: | | | `` |
| 5 1 × 5 | | 29b. Signature and t | trie of parting | hun | | | - | nse number | | 29d. Date signed | ı (Montn, | Day, Year) |
| | - | 20 Name and add | 164 | ione. | | - 00cl /= | 1)3 | > 100 | | terriary | 1 | 2000 |
| | | 30. Nama and addre | ess ot parson | wrio completed caus | a ot daath (iten | | | KDr. | Prome | hom | mp | 21712 |
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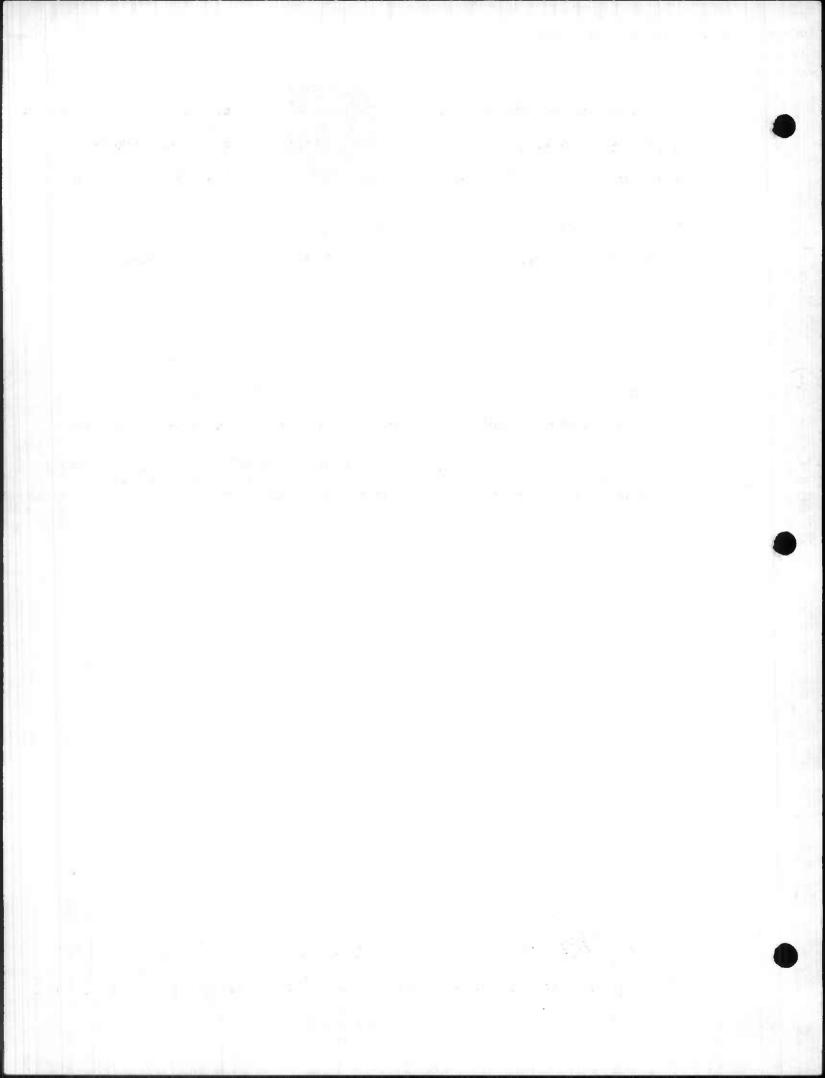
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Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Tyler John Wilson JANUARY 05, 2000 03:45 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Saint Joseph Medical Center Towson If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1₩ M 2□ F 45 Jan 5, 2000 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Severna Park Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 Mansfield Court 21146 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ² Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Merried 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Susan Beth Miller Mark Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 506 Mansfield Court, Severna Park, MD 21146 Mark Wilson/ father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremetion 3 ☐ Removal from State Jan 21 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2000 22. Name end Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Ligen 23a Anti. Enter the disease, or complications that caused the death too not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approxima Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) SEVERE PREMATURITY Due to (or as a consequence of) PRETERM LABOR & DELIVERY Due to (or as a consequence of): c CHRONIC ABRUPTION PLACENTA Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

attending physician and for usa as the burial-transit

by

Completed

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Certification: To

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The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

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After or Attanding

To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun

Physician

/Medical

Examiner

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10a. State

Funeral

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permit. Pages 1 and 2 should be lifed Department of Health and Mental Hygis Important. If hem 27 is marked other any injury or other treumedic event. It

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 22 No 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

00051751

00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE TOWSON, MARYLAND 21204 SARA WHEELER. M. D. . 31. Date filed (Month, Day, Year)
JAN 2 7 2000 32. Registrer's Signature

State Registrar

JAN 2 7 2000 December 1

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

| AMEND# 0 | 01 | State of Maryla | | | | | UL | 05326 |
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| Examine | Hospice of the Cl | nesapeake Res | idence | | Linthicum | 1 | Anne A | rundel |
| Funeral | Social Security Number 6. Security Number | M | Me | Under 1 Year onths Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | th Iv. Year) | 9. Birthplace (State or Foreign Country) |
| Director | 197-03-0347 | M 2□ F 83 | Yrs. | on the original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original original origi | 1.00.0 | | | Pennsylvania |
| P . | Usual Residence of Decedent 10a. State 10b. County | 10c C | ity, Town or Location | 00 | | | <u> </u> | 10d. Inside City Limits |
| the Marylar 28a-f show northed at | MD Anne Ar | | illersvil | | | | | 1 ☐ Yes 2 ☐ No |
| 28a-f | 10e. Street and Number | araci m | | Of. Zip Code | | | 10g. Citizen of V | |
| With With | 330 Overcup Cour | - | | 21108 | | | USA | |
| death with the Maryland ms 23s or 28s-f show mast be notified at hers! Director | 11. Merital Status | 12. Wes Decedent Ever in | US 13 Wes | | lispanic Origin? (S | pecify Yes or No | | a - American Indian, |
| 5 2 2 5 | 1 Never Married 2 Nerried 3 Widowed 4 Divorced | Armed Forces? 1 □Yes 2 □ No | | s, specify Cub Yes 2 No | lispanic Origin? (S an, Mexican, Puerti Specify: | Rican, etc.) | Specify Specify | k, White, etc. |
| 15-00: natural: | 15. Decedent's Ed | ucation | 16a. Decedent' | s Usual Occup | ation | | 16b. Kind of Bu | siness/Industry |
| we | (Specify only highest gred Elementary/Secondary (0-12) | de completed) College (1-4or 5+) | (Give kind life. DO N | of work done VOT use retired | during most of world) | king | | |
| 21 d with | 12 | Conogo (1 40/ 54/ | Meat Co | utter | | | Food | Service |
| be file file of other sent | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | ne (First, Middle | , Maiden Sumam | e) |
| Vla Went Ment Ment Ment Ment To | John Wojciechowic | Z | | | Frances | M. Maga | arovich | |
| Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygienthent of Health and Mental Hygienthent of Health and Mental Hygienthent of Health and Mental Hygienthent of Health and Mental Connection of the Mental Hygienthenthenthenthenthenthenthenthenthenth | 19a. Informant's Neme/Relationship (7 Lillian Wojciecho | | | | and Number or Ru Court, Mi | | | State, Zip Code) 21108 |
| altimore, mir. Pages 1 ar partment of Hea portant: It Nem 3 y Injury or other 25. | 20a. Method of Disposition | | Pleca of Disposition cemetery, cremato | n (Name of | ce) | Jan 25 | 20c. Location - | City or Town, Stata |
| Page Nent Indiana | 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify | | Veterans | | | 2000 | Crownvs. | ille, MD |
| Balti Departi Importa any inju | 21. Signalatie of Fupriori Service Little | 5 | Barı | | ss of Facility Sons, P | | | k Funeral Home rk, MD 21146 |
| | 23a Part Enter the disease, or comp | licetions thet ceused the dec | | | | | | Approximate Interval Between |
| Physician /Medical Examiner | Immediate Ceuse (Finel disease or condition resulting in death) | . Seve | ul aut | ic st | | | | Onset and Death |
| | | | | 33 37. | | | | 1 |
| ate be executed trysician and the burial-transit | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury | Due to | or as e consequent | ce of): | | | | |
| 9 9 0 0 | cause (Disease or Injury that initiated events resulting in death) Last | C Due to (| or es e consequenc | ca of): | | | | |
| Box 68 eath certific attending pl for use est | | d | | | | | | |
| O. Bc. he death the attention of the death ysiciar | Pert II. Other aignificant conditions co | ntributing to death but not re | sulting In the under | tying cause giv | ren in Pert f. | 23b. Did | tobacco use cor | ntribute to the cause of death? |
| P. d by d by Jetac | canoted atreal ful | stenosis | | _ 4_ | | 10 | Yes 2□ No | 3 Probably 4 Unknown |
| COFC requir | atreal ful | nelation | | | | | an autopsy omed? | 24b. Were autopsy findings available prior to completion of cause of death? |
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| Attending Physical Control of Attending Physical Control octor: After this by the funeral diffication: To | 27. Manner of Death Natural 5 Pending Decident investigation | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injur Wor M 1 | yat k? Yes 2 □ No | 28d. Describe | how injury occurr | ed |
| Division of the or Attending P as or Attending P as Director: After led in by the funers Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At I building, etc. (Spec | nome, farm, street, | factory, office | | 28f. Location (City or To | | er or Rural Route Number, |
| Division of Vital Remotes Physicien: The Invitin 24 hours after death. To the Funeral Director: After this certificate his completely lilled in by the funeral director, page Medical Certification: To Be Com | | sician: To the best of my kn iner: On the basis of examin and menner steted. | | | | | | |
| To th within To th Comp | 29b. Signature and title of partition | | | 29c. Licens | | | | d (Month, Day, Year) |
| | Om a Um | nung | | 02 | 1421 | | JAN. | 24,2000 |
| | 30. Name and address of person who c | ompleted cause of death (Ite Z/Mo// | m 23a) (Type, Print | - | | 1300 1 | ma z | 1045 |
| State Registrar | 31. Date filed (Month, Dey, Year) JAN 2 7 200 | 32. Registrar's Sign | eture 4 | Ann . | 41 | | IP1 | |

DHMH 16 Rev 6/95

JAN 2" 2005 " 2 WAL

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State of Maryland / Department of Health and Mental Hygiene 0 5 3 2.7

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| | 1. Decedent's Name (First, Middle, Las | 1) | | | | | 2. Date of De Month | eath Dey | 3. Time of Death |
| Physician /Medical | MARTHA B. WA | LKER | | | | | | 27 2000 | 6:25 pm |
| Examiner | 4a Facility Name (If not institution, give | street and number) | | | 41 | b. City, Town, o | r Location of Deat | th 4c. County | of Death |
| | MARINER HEALTH | NORTH ARUI | NDEL | | | EN BUR | | ANNE | ARUNDEL |
| Funeral Director | 215-01-6985 | 7. Age (In y | rs. last birthd Yrs | Months | er 1 Year Deys | If Under 24 Hr Hours Mir | | ay, Year) | Birthplace (State or Foreign Country) MARYLAND |
| P | Usual Residence of Decedent 10e. State 10b. County | 10c. | City, Town o | r Location | _ | | | | 10d. Inside City Limits |
| fathe Por | MARYLAND ANNE A | DIINDEI C. | EVERN | | | | | | XXYes 2 No |
| or 28a-f sh be notified. | 10e. Street and Number | KONDEL 5 | EVENI | | ip Code | | | 10g. Citizen of W | /hat Country? |
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| iners 23 iner must Funeral | 8210 AUTUMN LAK | 12 Was Decedent Ever In | U,S. | | 1144 edent of His | spanic Origin? (| Specify Yes or Norto Rican, etc.) | US) 0- 14. Race | - American Indian, |
| by by | 1 Never Merried 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: | | | | Specify: | rto Rican, etc.) | | k, White, etc. BLACK |
| ypiene. Ar the Medical Completed | 15. Decedent's Ed | ucetion | 16a. De | ecedent's Us | uel Occupa | ition | and down | 16b. Kind of Bu | siness/Industry |
| Med a | (Specify only highest grad Elementery/Secondery (0-12) | College (1-4or 5+) | - (G | ive kind of w ie. DO NOT | vork done d use retired) | furing most of w | orking | | |
| the the | 7th | 0 | | HOUSE | WIFE | | | NONE | |
| Be Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's No | ame (First, Middle | , Maiden Sumam | 9) |
| Ment wife a | THOMAS BROO | KS | | | | ETH | EL ARTI | HUR | |
| and and | 19a. Informant's Name/Relationship (7 | ype, Print) | 19b. M | feiling Addre | ss (Street a | and Number or I | Rural Route Numb | per, City or Town, | State, Zip Code) |
| 27. | RAYMOND WILSON | (SON) | 821 | O AUT | 'UMU' | LAKE C | T. SEVI | ERN, MD | . 21144 |
| E H | 20e. Method of Disposition | | . Place of Di | isposition (N | ame of other place | 9) | Date | 20c. Location - | City or Town, State |
| nt: If its | 4 □ Donation 5 □ Other (Specify | | T. TA | BOR C | HURC | H CEME | . 2/4/2 | 2000 ANI | NAPOLIS, MD. |
| Target at | 21. Signeture of Funeral Service Licens | | | 22 Name | and Addres | s of Facility | | | |
| OF PR | DT HA | | | | | | | JARY, P | |
| | 23a. Part1. Enter the disease, or confp | lications that caused the de | | | | | | S, MD. | Approximate |
| nysician | shock, or heart feilure. List only o | one cause on eech line. | | | | _ | | | Onset and Death |
| Medical | Immediate Cause (Final | (t | 14.40 | 0 | 4 | P. O. | | | 9 2000 |
| caminer | diseesa or condition resulting in deeth) | a. (onger! | (Or as a cor | nsequence of | n: 17 | ALTUSE | , | | 12 years |
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| physician and s the burlat-transit edical Examiner | Sequentially list conditions | b | o (or es a con | nsequence of | 1): | | | | |
| | Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | |
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| D # - | resulting in death) Last | | | | | | | | |
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| the att hed to ysicia | Pert II. Other algnificant conditions co | ntributing to death but not i | resulting In th | ne underlying | cause give | n in Part i. | 23b. Did | tobacco use cor | ntribute to the cause of death |
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| certificate rector, pag | 25. Was case referred to medical | | | | | 26 Place of D | eath (Check only | one) | |
| | examiner? | Hospital: 1 Inpatient 2 | □ ER/Outpa | atient 3D (| Othe | ar. | | idence 6 Othe | er (Snecify) |
| A | 27. Manner of Death | 28a. Date of Injury | 28b. Tim | ne of | 28c. Injury | at | | how injury occurr | |
| eath. or: After the funer cation: | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day Year |) Inju | iry M | Work | res 2 □ No | | | |
| rs after death. al Director: After the in by the funeral Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - A building, etc. (Spe | | , street, facto | ory, office | | 28f. Location City or To | (Street and Number own, State) | er or Rurat Route Number, |
| Funer Funer stely fill dical | | raician: To the best of my kiner: On the basis of examend menner stated. | | | | | | | |
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| | 711 | (Ve'(() | | | VIO | 100 | | / / | |
| | 30. Name and address of person who c | ompleted cause of deeth (I | | 0 | 1 | . / 4 | 100 0- | 1+ | WA 21112 |
| | 21 Date Hild athort Day | oruther the | 13 Han | ofolu | - OKO | ray ff | 100 00 | enton 1 | NU 21113 |
| State Registrar | 31. Date tilled (Month, Day, | 32. Registrar's Sig | gneture | 9. 2 | Loon | 61 | | 75 | |

FEB 0 2 2000 pages /

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | Certif | ficate of l | Death | , | Reg. No. | 15328 |
|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------|-----------------------------------------------------|-----------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------|
| Physician | 1. Decedent's Name (First, Middle, La | | | | | 2. Date of Dea | | 3. Tima of Death |
| /Medical | Willa Dean | Wil | <u> </u> | | | January | 31, 2000 | 6:00 am |
| Examiner | 4a Facility Name (If not institution, given | | | 4 | lb. City, Town, or | Location of Death | 4c. County of De | eath |
| | 148 Berrywood Di | rive | | | Severna | Park | Anne Aru | undel |
| Funeral Director | 417-32-5212 | Sex 1 M 2 F 7. Age (In yrs. 78 | | f Under 1 Year fonths Days | If Under 24 Hrs Hours Min | | v, Year) | lirthplace (State or Foreig Country) abama |
| Pu . | Usual Residence of Decedent 10a. State 10b. County | 10c Ci | ty, Town or Locati | ion | | | | 40d Incide City Line |
| show show | | | | | | | | 10d. Inside City Limit |
| Ne Maria | | rundel Se | everna Pa | | | | | |
| iter deeth with the Mai r items 23s or 28s-1 s inc. met be northed Funeral Director | 148 Berrywood Dr | rive | | 101. Zip Code 21146 | 5 | 7 (3) | 10g. Citizen of What USA | Country? |
| by | 11. Marital Status 1 Never Married 2 Merried 3 XWidowed 4 Divorced | 12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | s Decedent of H es, specify Cube Yes 2 No | ispanic Origin? (S an, Mexican, Puer Specify: | Specify Yes or No- to Rican, etc.) | | nerican Indian, hite, atc. White |
| "natural", | 15. Decedent's E (Specify only highest gri | | 16a. Decedent | t's Usual Occup | ation | arkina | 16b. Kind of Busines | ss/Industry |
| c * * = = | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO | NOT use retired | during most of wo | *A#J | | |
| should be filed within nd Mental Hygiene. marked other than americ event, the Me | | 2 | Home | maker | | | Home | |
| | 17. Father's Name (First, Middle, Last | • | | | 18. Mother's Na | me (First, Middle, | Maiden Surname) | |
| d benta | Willard McClella | an | | | Alice | Jackson | | |
| d 2 should be f th and Mental b 7 is marked of traumatic eve | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Mailing A | Address (Street | and Number or R | ural Route Numbe | or, City or Town, State | , Zip Code) |
| 0 a m m | Edward Will, Jr. | | | | | | Park, MD | |
| of Health Hern 27 | 20a. Method of Disposition | 20b. F | Place of Disposition | on (Name of | 7 | Date | 20c. Location - City | 21146 or Town State |
| permit. Pages Department of I Important: If Ite any Injury or of pdice. | 1 ☐ Burial 2 ☑ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | Removal from State | etro Crer | ory or other plac | >e) | Feb 1 2000 | Baltimor | |
| death certificate be executed e attending physician and od for use as the burial-transit of for use as the burial-transit of control examiner | 23a Part Enser the disease, or common or heart failure. List only immediate Cause (Final disease or conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | e. Due to (c Due to (c Due to (c | or as a consequent or as a consequent | nce of): ~ | - fu | bull | | Approximate Interval Between Conset and Death |
| des ed fe | Part II. Other algnificant conditions of | contributing to death but not res | ulting in the unde | rlying cause give | en in Part I. | 23b. Did t | obacco usa contribu | rts to the cause of dea |
| ss that the death cer igned by the attendir be deteched for use by Physician/A | <u> </u> | | | | | 104 | 108 2 No 3 | Probably 4 Unkn |
| aw requir is been s 2 should pleted | | | | | | 24a. Was a perfor | an autopsy med? | b. Were autopsy finding available prior to completion of cause of death? |
| The Late has page | | | | | | 1 🗆 Y | es 2DNo | 1 ☐ Yes 2 ☐ No |
| ystcien: The securificate director, pag | 25. Wes case referred to medical examiner? | | | | 26. Place of De | ath (Check only o | ne) | |
| 2 00 2 | 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatient | 3 DOA Oth | er: 4 Nursing F | Home 5 - Resid | lence 6 Other (S | pecify) |
| Attending Ph r death. ector: After th by the funeral | 27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injun Worl M 1 | y at k? Yes 2 □ No | 28d. Describe h | now injury occurred | |
| 3 0 5 | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 28e. Place of Injury - At he building, etc. (Specif | ome, ferm, street, y) | fectory, office | | 281. Location (S City or Tow | | Rural Route Number, |
| To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b Medical Certil | 29a. Certifier 1 Certifying Ph | nysician: To the best of my kno niner: On the basis of examina and manner stated. | wledge, death oo tion and/or invest | curred at the tim tigation, in my op | ne, date end piace pinion, death occu | e, end due to the ourred at the time, o | cause(s) end menner date and place, and d | as stated. lue to the cause(s) |
| To the compl | 29b. Signeture and title of certifier | Prai | | 29c. License | e number | 7 | 29d. Date signed (No. | onth, Day, Year) |
| | () | 2 | | | | | 0.00 | C 4-1 3 |
| | 30. Name and address of person who | completed cause of deeth (Item | 1 23a) (Type, Prin | nt) | | JEVE | AUT PAR | 4. ms. 211 |
| | JAMES J. BE | NJHMIN MI | 5. 47 | 7 Jan | pers 1 | OLERA. | Suite 30 | 4. |
| State | 31. Dete filed (Month, Day, Year) | 32. Registrer's Signe | ture 4 | don | 11 | | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician Melvin Bernard Wetzel /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 10₹M 2□ F Months Director 18 8689 217 **Usual Residence of Decedent** the Maryland 10s. State 10b. County 10c. City. Town or Location tem 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic avent, the Medical Examinar must be notified at Directo Maryland Washington Hagerstown 10e. Street and Number 10f, Zip Code 10 Brightwood Drive 21740 Funeral death 13. Was Decedent of His If Yes, specify Cuban 12. Was Decedent Ever in U,S. Armed Forces? 1 2 Yes 2 □ No WW If Yes, Give Year or Dates: 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: if Itam 27 is marked other than "natural", or its early injury or other treumatic avent, the Medical Examinations. 2 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 21 No p

| | 10g. | Citizen of What Country? | |
|------------------------------------------------------------------|---------------|---------------------------------------------------------------------|--|
|) | US | SA | |
| panic Origin? (Specify Yes, Mexican, Puerto Rican, etc. Specify: | or No- c.) | 14. Rece - American Indisn, Black, White, etc. Specify: White | |
| ion uring most of working | 16b | b. Kind of Business/Industry | |

anusul 26,2000

4c. County of Death

Washington

Maryland

2. Date of Death

8. Date of Birth (Month, Day, Year)

April 6, 1924

Month

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa (Give kind of work done du life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker Planning Mill 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Claude Henry Wetze1 Mary Kemp

Rebecca Wetzel Wife 10 Brightwood Drive Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State

Cedar Lawn Memorial Park 1/29/00 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Gerald N. Minnich 21. Signature of Funerel Service Licensee 305 N. Potomac St. Funeral Home Hagerstown, Md.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death 24 hous

25. Was case referred to medical

19a. Informant's Neme/Reletionship (Type, Print)

3 ☐ Widowed 4 ☐ Divorced

Completed

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certificate has

To the Hospital or Attending Physical thin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

Nelvin BungRD Wetze

essovas Due to (or as a consequence of)

years

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

2050

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of death?

200 No

No No 1 Yes

26. Place of Death (Check only one)

| 1 Yes 2/2 No | | Hospital | Inpatient 2 | ER/Outpatient | 3 🗆 (| OOA Othe | C 4□ Nursing | Home 5 ☐ Residence 6 ☐ Other (Specify) |
|-------------------------------|-------------------------|----------|-----------------------------------------------|---------------------|----------|---------------------|--------------|---------------------------------------------------------------------------------|
| 2 Accident | 5 Pending investigation | | Date of Injury (Month, Day Year) | 28b. Time of Injury | М | 28c. Injury Work | at ? | 28d. Describe how injury occurred |
| 3 ☐ Suicide 6 4 ☐ Homicide | Could not be determined | 280. | Place of Injury - At h building, etc. (Specif | ome, farm, stree | t, facto | ory, office | | 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) |

3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1-27-10

Ti Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D28365

len 30. Name and address of person who comple cause of death (Item 23a) (Type, Print)

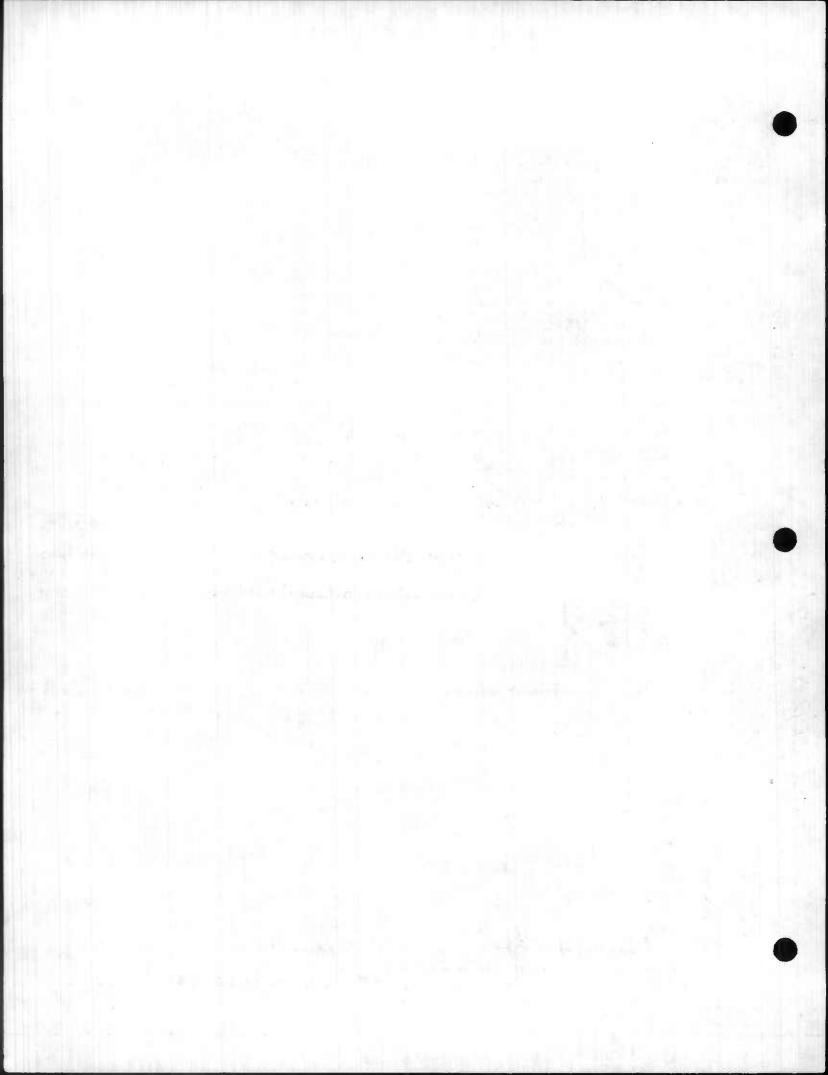
MD 21740 HAGBERS TOWN

State Registrar

31. Date filed (Month, Day, Year) JAN 2 8 2000

ZAR.

368 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death 27 1 Month Janice Elaine WHITE 4b. City, Town, or Location of Death 2000 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Washington County Hospital Hagerstown Washington Hours Min. 8. Date of Birth (Month Day Cear) April 30,1926 Mary Land If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F 220-16-3405 73 Yrs. Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ®CXYas 2□No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11403 Stonecroft Court 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates; Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) College (1-4or 5+) Jewelry Depart, Manager W. Bell & Company 18. Mother's Neme (First, Middle, Maiden Surnama) Albert Franklin Mongan Lena Kreglo

Elementery/Secondary (0-12) 17. Fathar's Nama (First, Middle, Last) 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mrs Sharon L. Carpenter/daughter 108 Woodcock Avenue, Shepherdstown, West Virginia 25443 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Jan. 2000 Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility

Minnich Funeral Home 1415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feiture. List only ona cause on each line. Approximate

Immediete Cause (Finel diseasa or condition rasulting in death)

Physician

/Medical

Examiner

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Funeral

Director

25a-f show

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Пета 23а

the Medical Examiner

Hygiena.

permit. Pages 1 and 2 should be file. Department of Health and Mental Hy important: if them 27 is marked other any linjury or other traumatic account.

Physician /Medical

Examiner

ettending physician and for use as the burial-transit

requires that the death certificate be executed

Box 68760.

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of Vital

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Physician/Medical

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Certification:

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Director:

To the Hospital or Attending in within 24 hours after death.
To the Funeral Director: After

Maryland 21215-0020

Baltimore,

Director

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32 on chegenic to (or as a consequence of) Interval Between Onset and Death year

Due to (or as a consequence of):

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or Injury that in the land are of the light of the land are of the light of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of the land are of that initiated events resulting in death) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

Pulmonary

1 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 Yes 2 HO

25. Was case rafarred to medical examinar? 1 Yes 2 No

Hospitat: 1 Dipatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28a. Date of Injury (Month, Day Year) 27. Mennes of Death 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

2000

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier

29c. License number

29d. Data signed (Month, Day, Year) 1-28-2000

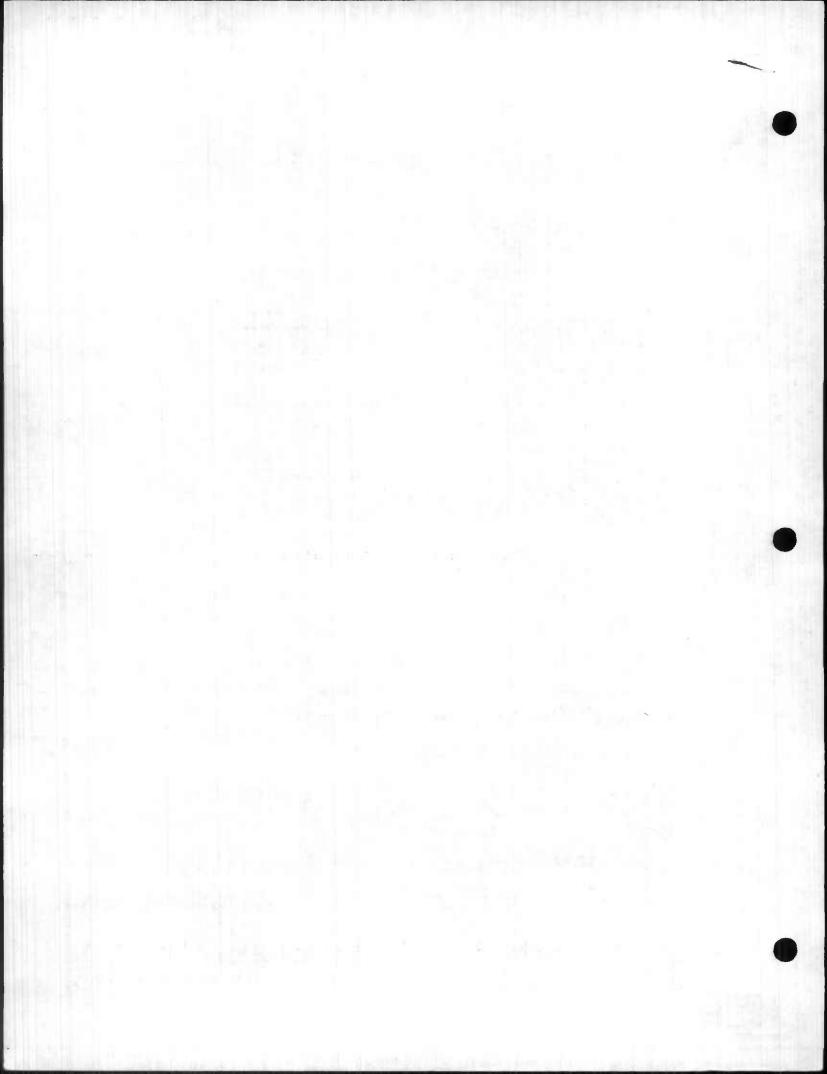
ABBUL WAITERD, MD-12821-OAKHILL 31. Data filed (Month, Day, Year)

JAN 31

32. Registrer's Signatura

AVE. HAGERSTOWN.

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death AMEND ITEM: #5 PER F.H. G781 3-23-2000 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Cardinal Richard Williams 2001 Jan /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Baltimore Deaton University of Maryland Medical Systems 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 17, 1929 9. Birthplace (State or Foreign Country) Virginia **Funeral** Days 1 M 2 □ F 70 **Director** Usual Residence of Decedent r 28a-f show inotified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Directo Virginia Arlington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Modical Examinar must be re 22204 United States 1301 South Nelson Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 (Ā/Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ATTICAN 1 Never Married 2 Married ardinal William 1 Yes 2 No Specify: þ American 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4th Elementary/Secondary (0-12) Lt. Colonel - U. S. Army Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rachel Hardy James Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5217 Ames St., N.E. Wash., D.C. Lorice E. Parson - Sister Mem 27 le 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of himportant: If its 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Arlington National Cem. 2/11/2000 Arlington, VA any Injury 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. rocuel 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoply, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical ACUTE MYDCARDIAL INFARCTION
Due to (or as a consequence of): Examiner Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE physician and the bunal-transit Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of): 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown END STAGE Renal Disense, Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed SHERAL DECUBITUR WLCER 1 Yas 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Delatural after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 24 hours a Hospital 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Junes P.G. Flynn 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) DEATION SPECIALTY HOSPITAL BII S. CHARLES ST. BALTIMORE MID JAHES FLYNN HD
31. Date filed (Month, Day, Year) 32, Registrar's Signature FEB 0 2 2000 Registrar

DHMH 16 Rev 6/95

well of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state

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| | hysicia /Medic | _ | 1. Decedent's Name (First, Middle, Last AMELIA | 1. Woos | 0501 | ME | | | 2. Date of De Month | Pay 30 | Yaar 00 | 3. Time of Death |
| | xamin | | 4a. Facility Neme (If not institution, give FORT WASHING | TON HO. | SPITA | | 1 | OKT WAS | HINGTO | m PRINI | | ORGES |
| Dire | neral ector | | 5. Social Security Number 6. Se 217–36–9358 | X 7. Aga | (In yrs. last l | Yrs. Month | dar 1 Yaar ns Days | If Undar 24 Hrs. Hours Min. | (Month, De | th ey, Year) 24,1912 | 9. Birthple Country Mary 1.8 | ca (Stete or Foreig y) and |
| he Maryland | Attied at | octor | 10a. Stete 10b. County Maryland Charles | | | wn or Location Indian | | | | | 100 | d. Inside City Limit |
| eth with th | sast be n | Funeral Director | 49 Greenwood Pla | | | | Zlp Coda 20640 | | | 10g. Citizen of USA | | |
| 5-0020 72 hours effer deeth with the Maryland | Examiner must be notified at | þ | 11. Maritel Stetus 1 □ Never Merried 2 □ Merried 3 ☒ Widowed 4 □ Divorced | 12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Yaer or Detes: | | 1 | cedant of H pecify Cubi 2 2 No | Ilspanic Origin? (Span, Mexican, Puarto Specify: | pecify Yas or No Pican, etc.) | | ca - America ick, Whita, at y: White | ic. |
| T . S . | the Madical | Completed | 15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12) | cation e completed) Coilege (1-4or 5+) | | a. Decedent's U (Give kind of life. DO NOT | work done use retired | during most of world) | king | Health | | stry |
| Maryland 212 d 2 should be filed with th and Mentel Hygiene. | atic event, | To Be C | 17. Father's Neme (First, Middle, Last) Samuel Lace | ey . | | | | 18. Mother's Nem Rena | | , Meiden Surnai | 71e) | |
| and 2 she salth and | Tracti | | 19e. tnformant's Name/Relationship (T) Mona Ann Bucci/Dau | | | | | and Number or Rus Solomons | | | , Stete, Zip C | iode) |
| Baltimore, emit. Peges 1 ar Department of Hea | ry or other | | 20e. Method of Disposition 1 Burial 2 Cremetion 3 F 4 Donetion 5 Other (Specify) | | 20b. Pleca cemei | of Disposition (f | verne of or other plea | | Dete | 20c. Location | | n, Stete Virginia |
| Balti Permit. Departm | any Inju | | 21. Signature Funerel Service Licens | aler | | 22. Neme Georg | and Addre | ss of Facility Kalas Fur Hill Rd. | neral Ho | ome, P.A | A. | 5 |
| Physi /Med Exam | dicai niner | 94 | Entar tha disease, or compined, or heart fellure. List only of the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in the compined in | | | o not enter tha m | oda of dyir | eg, auch as cardiac | or respiratory a | rreat, | 1 | Approximata Interval Between Onset and Death |
| Box 68760, with certificate be executed | the bu | n/Medical Examiner | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last | D. D. | | a consequence o | | 1// | | | 6 | dit. |
| O. 10 W | tached for | Physician/Me | Pert II. Other eignificant conditions cor | ntributing to death but | not resulting | in the underlyin | g cause giv | en In Pert I. | | tobacco use co | ontributa to t | the cause of death |
| cords, | 8 | Completed by R | | | | | | | | an autopsy ormed? | com | e autopsy findings lable prior to pletion of cause seth? |
| Ital Rec an: The law | page 2 | Comp | | | | | | | 10 | Yes 20 No | | Yas 2□ No |
| > 5 8 | 8 | o Be | 25. Was case referred to medical exeminer? | lospital: | A 17 5 5 16 | | DOA Oth | 28. Piace of Dee | | | | |
| Division of t or Attending Phys after death. Director: Atter this | fune | ⊢ - | 27. Menner of Deeth 12 Untural 5 Pending 2 Accident Investigation | 28e. Dete of Injury (Month, Dey | 28b | Time of Injury | 28c. Injur Wor | 4 LI Nursing H | | dance 6 Oti how injury occu | | |
| Divisi To the Hospital or Atten within 24 hours after deal To the Funeral Director: | filled in by t | Certification: | 3 Sulcide 6 Could not be determined | 28e. Plece of Injury building, etc. | (Specify) | | | | City or To | | | |
| e Hospital | completely t | edical | 29a, Certifier 1 Scartifying Physical (Check only one) 1 Madical Examination | alcian: To the best of a ner: On the basis of a and mannar stete | xeminetion e | ge, deeth occurre and/or investigati | ed et the tir on, in my o | ne, date and place, pinion, death occur | and due to the red at tha time, | cause(s) and m date and place, | anner as ata and due to t | ied. he cause(s) |
| To the verbin 2 | dwoo | _ | 29b. Signature and the or certifier | | | | PR Voens | e number 1943) | | 29d. Dete algne | od (Month, Da | sy, Year) |
| (1: | 5) | 1 | Fronk May Rayan 1 | mpleted cause of dee | LIUM | (Type, Print) | 1+2 | 205 F7. (| WASHI | region, | ND. | 20144 |
| Re | Stat egistra | | FEB 0 2 2000 | 32. Registrer | s Signeture | 6 1 | | v | | | | , |

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State of Maryland / Department of Health and Mental Hygiene

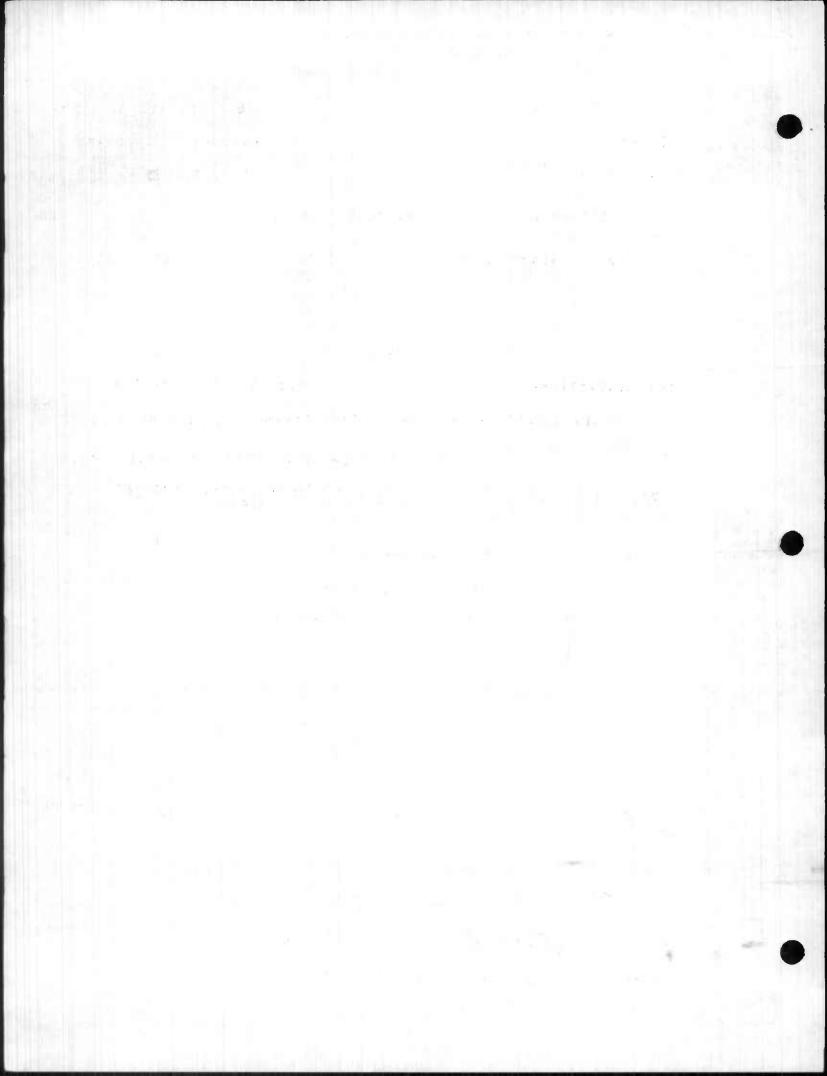
Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HELEN MAY WILLIS JANUARY 23,2000 11:35pm /Medical 4e. Feclifty Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Year if Under 24 Hrs. **Funeral** 9. Birthplece (Stete or Foreign 1□M 2X F Months Deys Hours CHESTER, PA 92 Yrs. Director 578-48-3306 Usuel Residence of Decedent a or 28a-f show 10e. Stele 10b. County 4 0/4 10c. City, Town or Location 10d. Inside City Limits Director TYPY 2 No PRINCE GEORGES TEMPLE HILLS the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "netural", or items 23a 3107 GOOD HOPE AVE APT 502 20743 Funeral UNITED STATES death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Deles: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 □ Never Merried 2 □ Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 XWidowed 4 □ Divorced the Medical 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filed wi tment of Heelth and Mental Hygien tant: If Item 27 Is marked other th ijury or other traumatic event, the DOMESTIC PRIVATE Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be WILL WHITE EMMA FONTAINE 19e. Informent's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SHARON COOPER / GRAND-DAUGHTER 2224 JAMESON ST. TEMPLE HILLS, MD 20748 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or 1-29-00 CLINTON, MD 4 ☐ Donetion 5 ☐ Other (Specify) FOREST HILLS CEMETERY 21. Signeture of Funeral Service 22. Neme end Address of Fecility ALEXANDER S. POPE FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 11185 5538 MARLBOR PIKE, FORESTVILLE, MD 20747 Approximate Interval Between Onset and Deeth **Physician** Cardio Pulmonary Arresi
Due to (or es a consequenca q1): /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that inhibited events resulting in deeth) Last Records, P.O. Box 68760, the Due to (or es a consequence of): USB as been signed by the etter should be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

(2 be 12) Melli 75 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings avelleble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical exeminer? 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 Neturel 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Hospital or Attendit 24 hours efter death. Funeral Director: Al stely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 24 hours dical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, end due to the ceuse(s) end menner as steted. 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. To the Within 2 To the 29c. License number 29d. Dete signed (Month, Day, Year) D0046374 1328 Southern Ave SE Washington DC 20032 se of deeth (Item 23e) (Type, Print) of address of person who cor 31. Date filed (Month, Day, State FEB 0 1 2000 Registrar

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| Physician Company E. Wickline February 4,200 1 | | | | | | | | Certificate of | | ornarriy | Reg. No. |) (| 0004 |
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| 200. Name and address of Parts 1 200. Name and address of Parts 1 200. Location - City or Town, St. | 2 ho | 100 | ted | 15. De | cedent's Ed | lucation (| 16a | . Decedent's Usuai Occ | upation | 4.2- | 16b. Kind of Bus | siness/Indu | stry |
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| WILLIAM GILL MD. 26423 BURTON AVE., CRIST-16-D. MD 21817 | | | - | 30 Name and address of - | Y Y | | oth /leam on- | | | | | | |
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| State 31. Date filed (Month, Dey, Year) 33. Registrer's Signature | | Sta | te | 31. Date filed (Month, Dey, | Year) | 39 Registre | r's Signature | | | | _ | | All A. A. P. Commercial Conference |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🗋 🗍 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Counth Month **Physician** Dolores Catherine Zepp February 2000 11:55 M l, /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** 320 N Main St Greensboro Caroline 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days Hours 212-28-5974 68 Yrs Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygione. Important: If them 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other treumatic event, its featest Examine must be notified as 1 Yes 2 No Director Maryland Caroline Greensboro 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 320 N Main St 21639 Funeral IISA 11. Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white Specify à 3 ☐ Widowed 4 🏋 Divorced Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Rehabilitation Tech. Mental Health Care 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Be Albert E Zepp To Margaret F Edmonds 19e. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Douglas Giles Son 320 N Main St Greensboro, Maryland 21639 20b. Plece of Disposition (Nama of cemetery, cremetery or other piece) 20c. Location - City or Town, State 20e. Method of Disposition Data 1 ☐ Buriel 2 M Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2-6-2000 Chester, Maryland Chesapeake Crematory 21. Signeture of Funeral Sarvice Licensee 22. Name end Address of Fecility Fleegle & Helfenbein Funeral Home 23e. P. 1. Entar the disease, or complications the caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart feilure. List only one ceuse on eech line. Greensboro, Maryland 21639 Approximata Interval Batween Onset and Death **Physician** /Medical immediata Causa (Final disease or condition resulting in deeth) Examiner Dua to (or as a consequence of) Examiner physician end the burial-transit Sequentially list conditions, if eny, leeding to Immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initieted avants resulting in deeth) Lest Dua to (or as a consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown been signed by should be detec 1 Yes 2 No P 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? Completed completion of cause of daath? page 2 No No Be 25. Wes casa referred to medical 26. Piece of Deeth (Check only ona) examiner? Yes 2□ No Othar: 4 Nursing Homa 2 5 Rasidance 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Naturel 5 Panding Investigation 2 No 1 Tes 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) Pleca of tnjury - At home, farm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicida 29a. Cartifier Partifying Physician: To tha best of my knowledga, daath occurred at the time, date and place, and dua to tha cause(s) and mannar as stated. Medical Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year)

32. Registrar's Signature

State Registrar

31. Dete filed (Month, Day, Yeer)

FEB - 4 2000

death with the Maryland

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

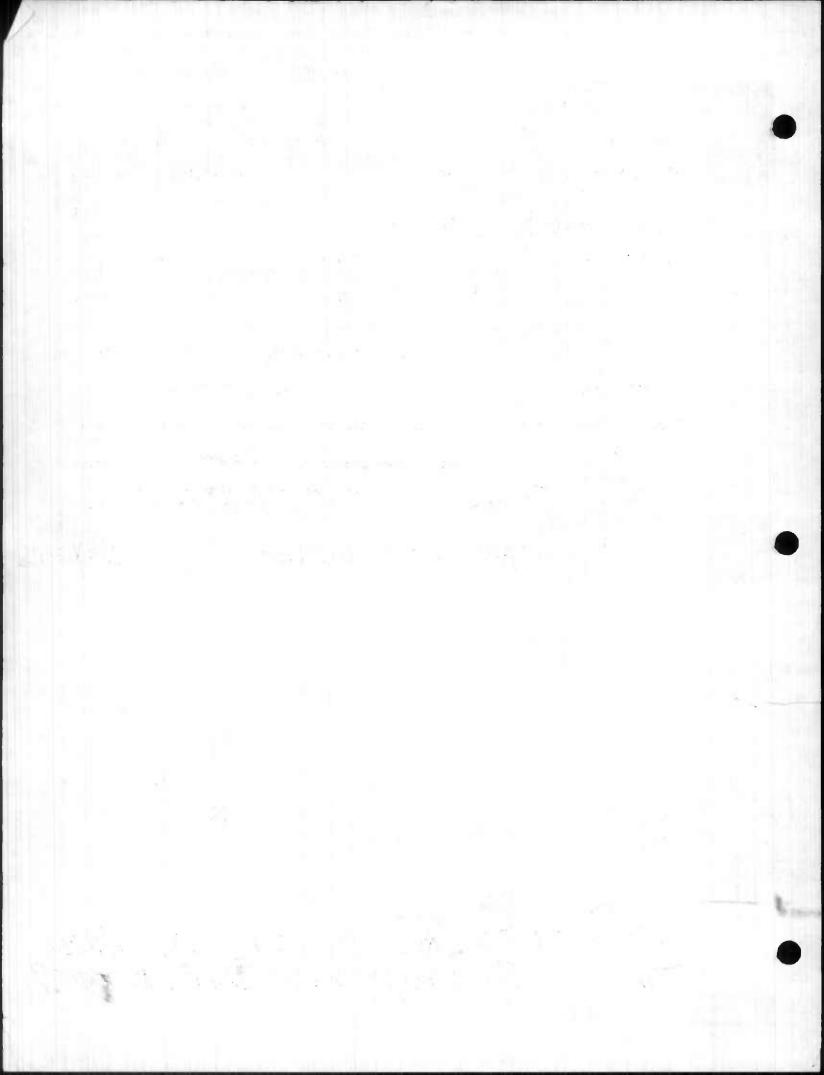
Division of Vital Records,

To the Hospital or Attending Physician: The law within 24 hours efter death.

To the Funeral Director; After this certificate hes

funeral

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** February Ruth Genevieve Brightman 13 2000 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Fallston General Hospital Fallston Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 20F Yes 214-01-3906 Director May 17,1906 Balto.MD. Usual Rasidance of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or hams 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford BelAir the 10e Street and Number 10f. Zio Code 10g, Citizen of What Country? 1809 Othello Court 21015 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 (2) No If Yas, Giva Yeer or Detes: 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 M Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Switchboard Operator 12 yrs. n/a Bell Telephone permit. Pages 1 and 2 should be file Department of Health end Mental Hy Insportant: If item 27 is marked other any injury or other traumatic event once. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Harry Kaiser Jessica O'Sullivan Lo 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs.Rose D.Brightman (Daughter IL) 1809 Othello Court BelAir, MD. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Removal from Stata 4 □ Donation 5 □ Othar (Specify) Lorraine Park Cemetery 2/16/2000 Woodlawn, MD. 21207 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD. 21087 apa 23a. Part 1. Entar tha disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failura. List only ona cause on each line. Approximate Interval Between Onset and Death Physician 15 Chemic Bow /Medical Immediate Cause (Final disaasa or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner sepsis physician and the burial-transit Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Couse (Diseesa or Injury that Initiated evants rasulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Attending Physician: 8 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 PNatural 5 Panding 1 Yes 2 No death. Invastigation 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 4 ☐ Homicida

To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

JENEVIEU E

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29a. Cartifier

(Check only one)

29b. Signatura and titla of contified

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30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

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32- Bagistrar'a gonature

Registrar

DHMH 16 Rev 6/95

ORIGINAL

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated.

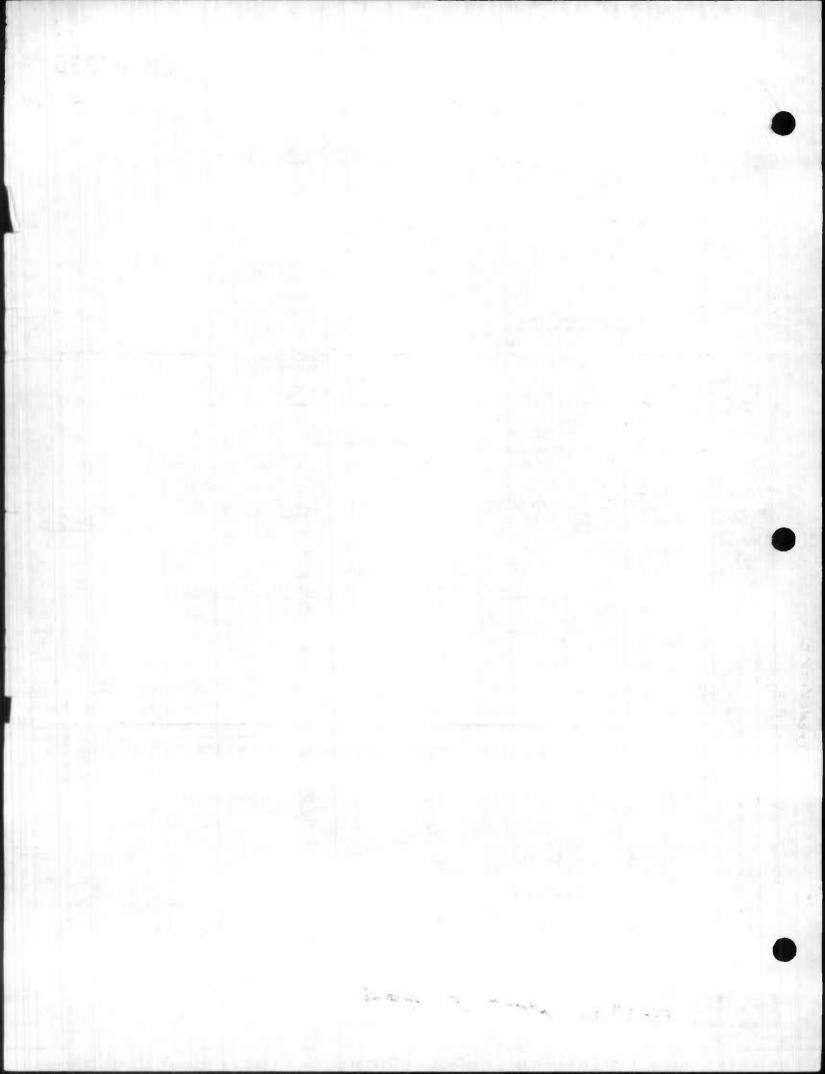
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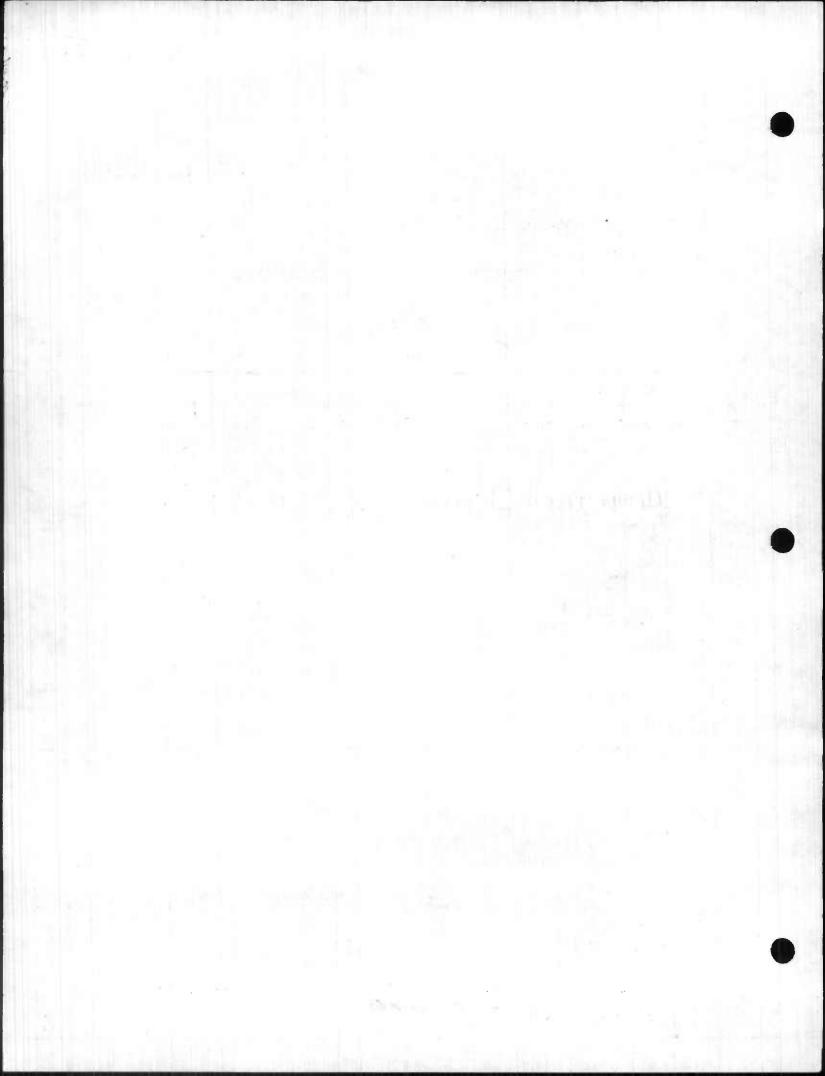
29d. Date signed (Month, Day, Year)

Afgra Drive, 20 Bel AIR MO 21014

February 13 - 2000



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| or Name | by Funeral Director | 710000 | rried 2 Merr | ried 1 [| /es Decedent rmed Forces? Yes 2 X Yes, Give ear or Dates: | ? | | Wes Decedent if Yes, specify | , | nic Origin lexican, F pecify: | 7 (Spe Puerto F | cify Yes or N Rican, etc.) | o- 14. R B | leck, Whi | erican Indian, te, etc. | |
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I death? Juknown Indings |
| Physician: The law requires that the death certificate be associed to this certificate has been signed by the attending physician and in principle as the burial-transit and process, page 2 should be detached for use as the burial-transit and process. | edical Certification: To Be Completed by Physician/Medical | Immediete Cause disease or condition resulting in death) Sequentially list or if any, leading to it any, leading to it any, leading to it any, leading to it and the cause. Enter Und Cause (Disease or that initieded even resulting in death) Part II. 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Date of Injumonth, Da a. Place of Injumonth, Da c. 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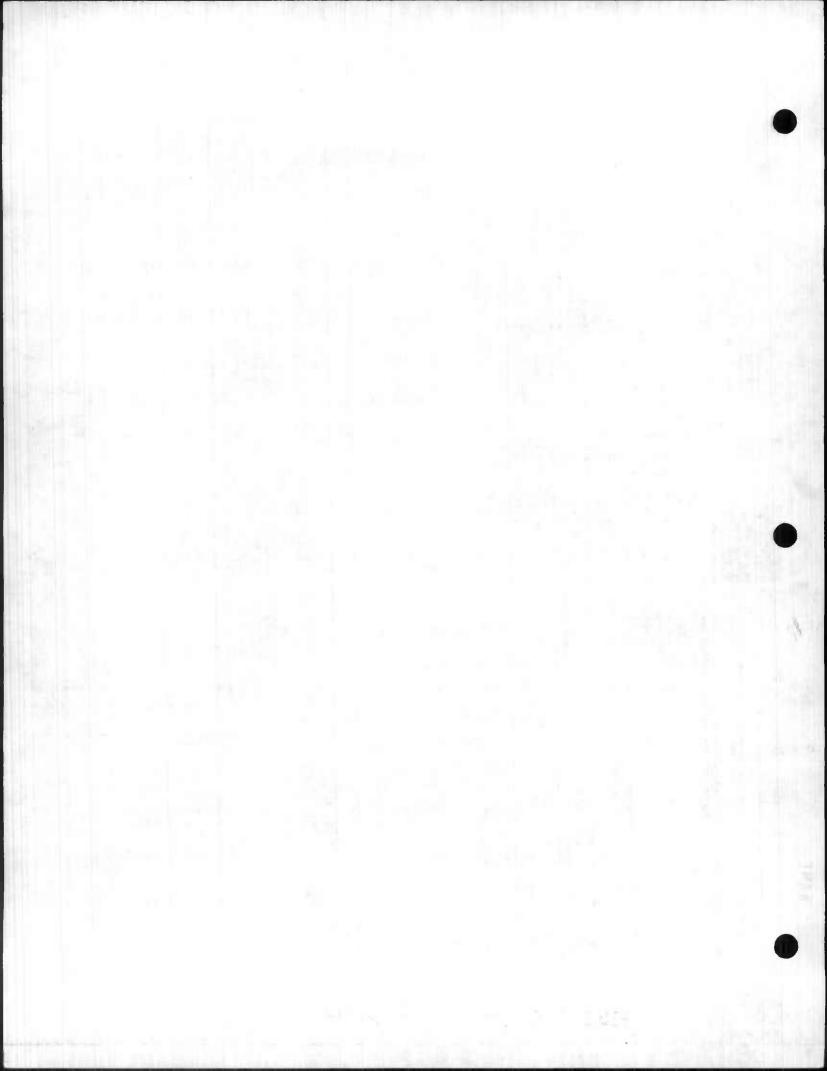
| | 1. Decedent's Neme (First, A | tiddle, Last) | · | | | | | 2. Date of | | Year | 3. Tima of Death |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------|---------------------------------|----------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------|-----------------------|---------------------------------------------------------------------------------|
| an cal | ROBERT BITTN | ER | | | | | | Fel | | 2000 | 031. 15 PM |
| | 4a Facility Name (If not insti | tution, give stre | et and number) | | | | 4b. City, Town | n, or Location of C | Death 4c. Co | ounty of Death | |
| | ST. AGNE | S H | OSPI. | TAL | | | BY | 72TIMO | RE | N | I/A |
| | 5. Social Security Number | 6. Sex | 7. As | e (In yrs. last b | | Inder 1 Year | If Under 24 | | Birth Day, Year) | 9. Birth | nplace (Stete or Foreign untry) |
| | 176-14-7645 Usual Residence of Deceder | | 2 F | 88 | Yrs. | , bays | THOUSE THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PRO | Feb | 7, 1912 | unki | nown |
| | 10a. State 10b. Co | unty | | 10c. City, To | wn or Location | 1 | | | | | 10d. Inside City Limits |
| to | MD An | ne Arun | de1 | Glen | Burnie | | | | | | 1 Yes 2 No |
| Funeral Director | 10e. Street and Number | | | | 10 | f, Zip Code | | | 10g. Citizer | n of What Cou | untry? |
| e la | 406 Morris | | | From in II C | 12 Wee 5 | lanced and the | 21061 | -2 (Casait, Van | US | A. Race - Ameri | igen ladies |
| by Fun | 11. Marital Statusunkno 1 Never Married 2 3 Widowed 4 Divo | Merried | Was Decedent Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates: | Nounknov | /n 1×1 | specify Cub | Specify: | n? (Specity Yes o Puerto Rican, etc | St | Black, White | |
| Completed | | edent's Educati | 22.0 | 16 | a Decedent's | Heual Occur | netion | hispanio | | his of Business/Ir | panic |
| 2 | (Specify only h | ighest grade co | empleted) | | a. Decedent's (Give kind of life. DO N | of work done OT use retire | during most o | of working | 100.1010 | 0. 000000 | |
| | Elementary/Secondary (0- | 12) | College (1-4or | | | - | | | | | |
| 3 | unknown 17. Father's Name (First, Mic | idle, Last) | unknow | II | | unknow | | s Name (First, Mi | ddle, Maiden Su | unknow mame) | n |
| 6 | unknown | | | | | | | | | | |
| 2 | 19a. Informant's Neme/Rele | tionship (Tune | Print) | 46 | h Mailing 44 | drace /Ctrans | | unknown or Rural Route N | umber City or T | own State 7 | in Code) |
| | St Agnes Hos | | · intij | 18 | | | | | | | |
| 1 | 20a. Method of Disposition | hirai | | 20h Place | of Disposition | | on Ave | Baltin | nore, MD | tion - City or T | |
| | 1 Burial 2 Cremet 4 Donation 5 Other | er (Specify) | ovel from State in stat | cemet | ery, cremator | y or other pla | | | | | |
| | 21. Signature of Funeral Ser JOS | eph B. | Van San | t | | ne and Addre te Ana timore | - | Soard 655 21201 | W. Bal | timore | Street |
| 1 | 23a. Part 1. Enter the diseas shock, or heart failure. | e, or complicati | ons that cause | d the death. Do | | | | | ory arrest, | 1 | Approximate Interval Between |
| | SHOOK, OF HEALT ISSUED. | List Only One C | ause 011 6601 1 | iro. | | | | | | 1 | Onset and Deeth |
| | Immediate Cause (Finel disease or condition | | | CIER | SIS | | | | | 1 | 10 mays |
| | resulting in death) | a | | Due to (or as | | e ou. | | | - | | 10 11/2 |
| 5 | | | | 000 10 (01 83 1 | o consequence | 0 01). | | | | 1 | |
| CXaminer | Sequentially list conditions, if any, leading to immediate | b. — | | Due to (or es a | consequence | e of): | | | | | |
| П | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | C | | Due to (or as a | consequence | e of): | | | | | |
| | resulting in death) Last | d | | | | | | | | | |
| | Part II. Other significant con | ditions contrib | uting to death b | out not resulting | in the underly | ring cause giv | ven in Part I. | 23b. | Did tobacco us | e contribute | to the cause of death? |
| - | Aprito | remal | Pa. C | مررر | | | 2 | | 1 Yes 2 | No 3 Pr | obably 40 Unknown |
| 1 | Tourt | | 1000 | - A E | | | | | | | |
| | | | 0 | | | | | 248. | Wes an autopsy performed? | a | Vere sutopsy lindings available prior to completion of cause of death? |
| | | | | | | | | | 1 □ Yes 2 😿 | | Yas 207No |
| 1 | 25. Was case referred to me | dical | | | | | 26 Disor | of Death (Check o | 1, | | - 12 |
| | axaminer? | Hosp | oitel: | ont of Ep. | Outpatient 3 | T DOA OH | hom | | | TOther /Sec- | riku) |
| - | 27. Manner of Death 1 Natural 5 Pe | ending | 1 2 Inpati 28a. Date of Inju (Month, Da | | Time of Injury | 28c. Inju Wo | ry at | | Residence 6 L ribe how injury o | | ну) |
| and ii | 3 Suicide 6 □ Co | restigation ould not be termined | 28e. Place of In | jury - At home, c. (Specify) | | | Yes 2□N | 28f. Locat | ion (Street and I or Town, State) | Number or Ru | ral Route Number, |
| TITICA | | | | | | | | | Wil | | |
| Continue | <u> </u> | | | | | | | place, and due to occurred at the t | | | |
| Medical Certification: | | | On the basis of end menner st | | | | | | | | |
| Medical Certifica | (Check only 2 Med | rtifier | end menner st | | | 29c. Licens | se number | | 29d. Date : | signed (Month | n, Day, Year) |
| BOUNDA MARKET | (Check only 2 Med one) | rtifier | | | D | | se number | 04 | 29d. Date : | signed (Month | |
| | (Check only 2 Med one) 29b. Signature and title of ce | rtifier | end menner st | eted. | D | D | | 04 | 29d. Date : | signed (Month | n, Day, Year) |
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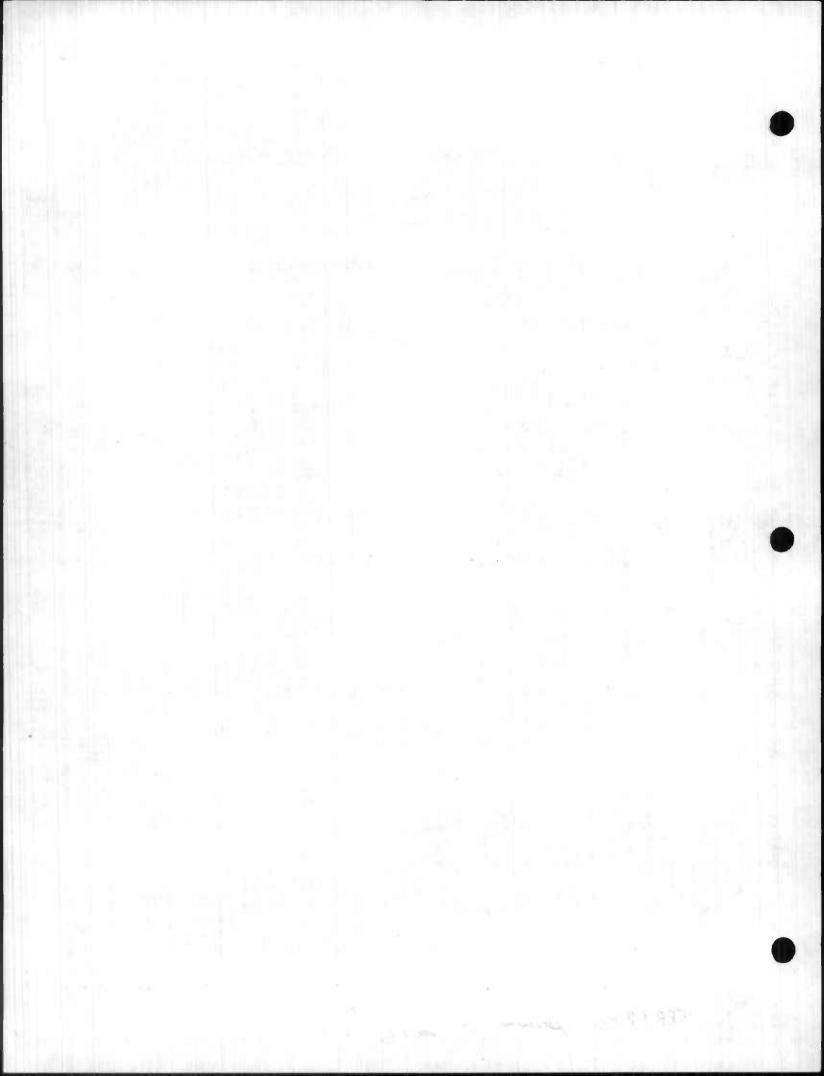
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| 3 | Physicia /Medica | n | 1. Decedent's Name (First, Middle, Last) | lackwell | Certifica | te of Death | 2. Date of Month | | Year 3. Time of Death |
| | Examine Funeral Director | er | 4e Facility Name (If not institution, give s HOYDOY 5. Sociel Security Number 215-14-4159 Usuel Residence of Decedent | Treet end number C 7. Age (in yrs. las | t birthday) If Und Month | Ba Ba If Under 24 | | -0 | 9. Bighplace (State or Foreign Country) |
| he Maryland | Ba-f ahow offind at | ctor | 10a. Stete 10b. County Maryland | A 10c. City, 1 | rown or Location | ore | | | 10d. Inside City Limits 1 Yes 2 No |
| 0 after death with the Maryland | r Rema 234 | Funeral | 10e. Street and Number 2803 Roun 11. Maritel Stetus 1 Never Merried 2 Merried | 2. Wes Decedent Ever in U,S. Armed Forces? | 13. Wes Dec | ip Code 2 2 5 edent of Hispanic Originating Courts, Mexican, | n? (Specify Yes o Puerto Rican, etc | .) Bla | se - American Indian, ck, White, etc. |
| 21215-0020 within 72 hours after | natural', | Completed by | 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12) | If Yes, Give Yeer or Detes: lation completed) College (1-4or 5+) | 16a. Decedent's Us | rork done during most d | of working | Specify 16b. Kind of B | Usiness/Industry |
| 64 5 | TPE | o Be Com | 17. Father's Name (First, Middle, Last) | Blackurell | lect | 18. Mother | s Neme (First, Mi | ddle, Maiden Syrnan | Corp. |
| 2 0 | of Health and Mental Rem 27 Is marked or r other traumatic eve | | 19e. Informent's Neme/Reletionship (Typ. | Blackwell | 19b. Meiling Address 2803 ee of Disposition (A | SS (Street and Number Round) | or Rural Route N | salto, M | d. 21225 |
| | Department of Health ar Important: If frem 27 Ia any Injury or other trau ptice. | | 1 Burial 2 Cremetion 3 Red 4 Donation 5 Other (Specify) 21. Signalure of Funerel Service Licensu | emovel from State Ga | etery, crematory of SOY 22. Neme | other place) FOREST and Address of Facility | L 2/22/2 | Owing Owing | City or Town, State S MILLS MD. |
| | ysician | | 23a. Part f. Enter the disease, or complication, or heart failure. List only on | cations that caused the deeth. | JOSEP 2222 Do not enter the m | W. North | AUQ, | Balto. N | Approximate Intervat Between Onset and Death |
| 1 | Medical caminer | 9 | Immediete Cause (Finel disease or condition resulting in deeth) a | Metastatic Due to (or a | Lung s a consequence o | Cance | r | | 5 months |
| 760, | | cai Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | Due to (or e | s e consequence o |): | | 25 | |
| Box 687 | g phys | Fnysician/Medic | that initiated events resulting in deeth) Lest | Due to (or es | s a consequence of |): | | | |
| P.O | d by the etached | Dy Physici | Part II. Other significant conditions cont | ributing to death but not resulting | ng in the underlying | cause given in Pert I. | 23b. | Did tobacce use co | ontribute to the cause of death? |
| e ec | has been sign | Completed b | | | | | | Was an autopsy performed? | 24b. Were autopsy lindings available prior to completion of cause of death? |
| | certificate harector, page | | 25. Wes case referred to predical | | | 26 Place o | of Deeth (Check of | 1□ Yes 2년 No | 1 Yes 2 No |
| Vision of Vitai | this id | 9 | examiner? | | VOutpatient 3 18b. Time of Injury | Other: | sing Home 5 28d. Desc | Residence 6 DOth | |
| Division or Attending | Director in by th | Certifications | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At home building, etc. (Specify) | s, ferm, street, fect | ry, office | 28f. Locat City o | ion (Street and Numi r Town, State) | ber or Rural Route Number, |
| Division To the Hospital or Attendi | within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Balandian Completely filled in by the funeral statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second statement of the second stateme | edical | 29a. Certifier 1 Octifying Physic (Check only one) 2 Medical Examination | cian: To the best of my knowle er: On the basis of examinetion and menner steted. | dge, death occurre end/or investigetion | d at the time, date and n, in my opinion, death | place, and due to occurred at the t | the cause(s) and mime, date and place, | anner as stated. and due to the cause(s) |
| | | - | 29b. Signature and little of certifier | -> | | RESON | 0 | Februo | |
| 11/ | State | | 30. Name and address of person who con MOHANAD BAK 31. Dete filed (Month, Dey, Year) | 32. Registrer's Signeture | 001 Sout | hHanover | st, B | paltimo | re, MD 21225 |
| DHMH | Registra 16 Rev 6/95 | | FEB 1 9 2000 See | f. A. | parts | | | | |

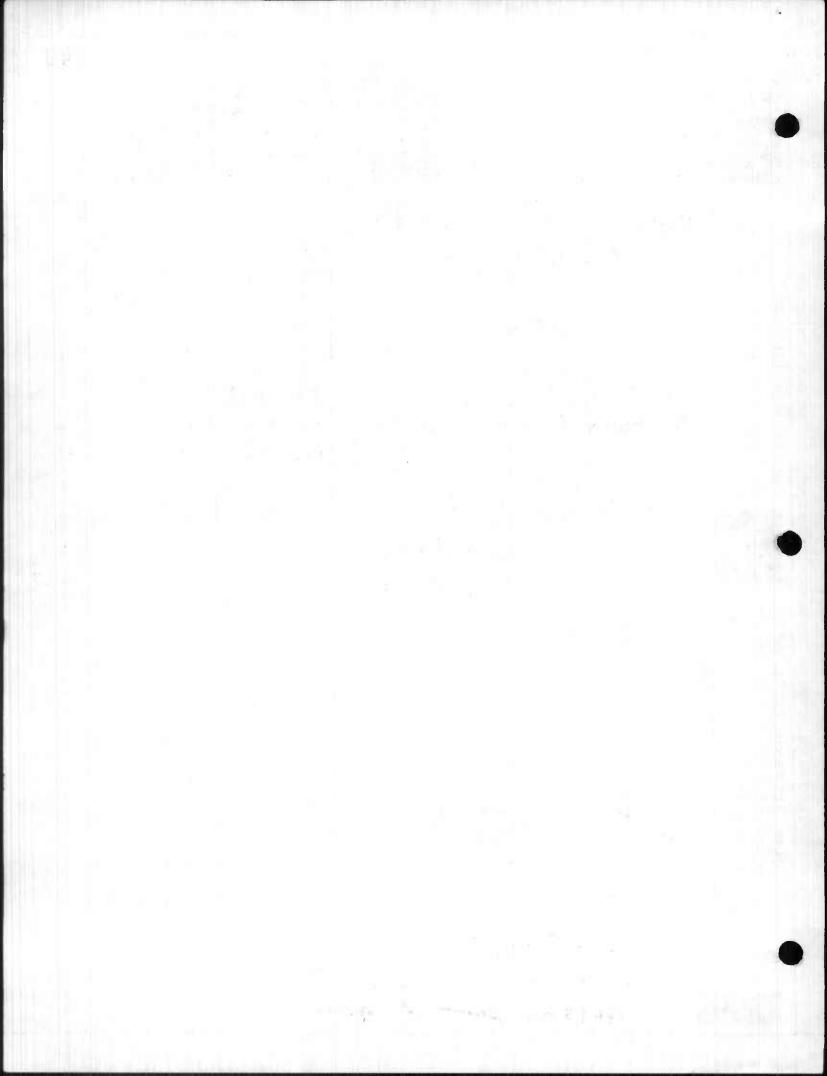
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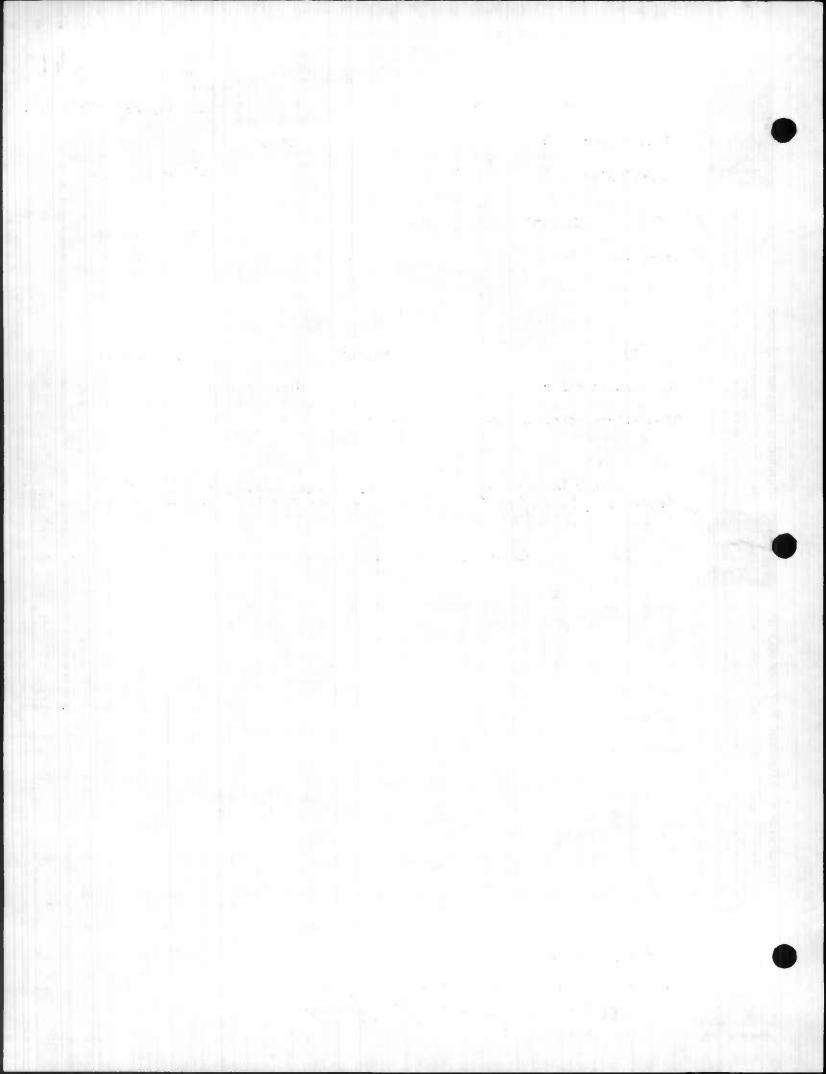
State of Maryland / Department of Health and Mental Hygiene 00 05340

| | | | | Certificate | of Death | Re | g. No. | 03340 |
|-----------------------------------------------------------------|------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------|--------------------------------------|-----------------------------------|------------------------------------------------------------------------------------|
| Physici | an | 1. Decedent's Name (First, Middle, Las | ") | 100 7.4 | | 2. Dete of Death | | 3. Time of Dea |
| /Medic | | WILLIE | A. | | CLARIX | FEBRUA | 1 | 2000 9:45 |
| Examir | ner | 4a. Fecility Name (If not institution, give | street end number) | 41 | 4b. City, Town, or | Location of Death | 4c. County o | of Death |
| Funeral | | 5. Social Security Number 6. Se | x 7. Age (In yrs. last | t birthday) If Under 1 | Year If Under 24 Hrs | 8 Date of Birth | Λ | 9. Birthplace (State or Fo |
| Funeral Director | | | DM 2XF 74 | Yrs. Months | Days Hours Min. | | 1925 | Vorth Caroli |
| death with the Maryland ms 23a or 28a-f show man be notified at | | 10a. State 10b. County | 10c. City, T | Town or Location | | | | 10d. Inside City Li |
| Ba-1 s | cto | Maryland N/ | 6 | altimo | ore | | | 1 XYes 2 |
| or 2 | Dire | 10e. Street and Number | 1 - 1 | 10f. Zip 0 | Code | 10 | g. Citizen of W | hat Country? |
| e 23e | erai | 509 N. FUL | ton Ave. | 2 | 1223 | | U | SH |
| | Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No | If Yes, specif | ont of Hispanic Origin? (S y Cuban, Mexican, Puer | pecify Yes or No- to Rican, etc.) | | - American Indian, , White, etc. |
| 72 hours after death v natural; or items 234 | by | 3 ☐ Widowed 4 ☑ Divorced | If Yes, Give Year or Dates: | 1 □ Yes 2 | No Specify: | | Specify: | Rlack |
| | | 15. Decedent's Edi | ication 1 | I6a. Decedent's Usual | Occupation | 1 | 6b. Kind of Bus | siness/industry |
| within 7 ene. than "r | Completed | (Specify only highest grad | College (1-4or 5+) | life. DO NOT use | done during most of wo retired) | rking | 100 | |
| Hygiene Hygiene ther tha | Con | 12 | 2 | Secr | etary | L | 1,5.6 | overnme |
| | Be | 17. Father's Name (First, Middle, Last) | 16.1 | | 18. Motifier's Na | ne (First, Middle, M. | aiden Sumame |) |
| Mental Mental Marked o | T _o | John Pell | ITO, a | | Marc | P.C | Jark | |
| th end 7 is me treum | | 19e. Informant's Name/Relationship (7) | po, Printerway (er) | 196. Mailing Address (| Street and Number or Ru | ural Route Number, | City or Town, S | State, Zip Code) |
| flem 27 other tr | | 20a. Method of Disposition | 20b. Place | e of Disposition (Name | WITON A | /Date/ 2 | Oc. Location - C | City or Town, State |
| | | 1 Burial 2 Cremetion 3 1 4 Donation 5 Other (Specify, | removal from Stete | etery, crematory or oth | ner place) | 2/21/200 | R-14 | 100 Md |
| , 돌름을 . | | 21. Signature of Funeral Service Licens | 11111 | 22. Name and | Address of Facility | 1 /2000 | Dalla | 0.0,1014 |
| Depe Impo any ir | | March | 440,11 | Joseph | L. Russ | Funeral | Home | 01011 |
| | | 23a. Party. Enter the disease, or comp shock, or heert failure. List only of | ications that caused the death. [| 2222 M | of dylng, such as cardla | or respiratory arres | -0. Ma. | Approximate |
| hysician | | shock, or heart failure. List only o | ne ceuse on each line. | | , | | | Interval Between Onset and Deet |
| /Medical | | Immediate Cause (Final disease or condition | Brank | mete st | 7~ | | | 10 |
| Examiner | | resulting in death) | 9. | s a consequenca of): | 7. 3-1 | | | 2 |
| St. St. | Examiner | | Lung Co | an cer | | | | 2 Ma |
| end I-tren | хап | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Doe to (or as | s e consequence of): | | | | |
| incere or executed in the puriel-trensit | | Cause (Disease or Injury | c | | | | | |
| og physician end es the buriel-trer | edicai | that Initiated events resulting In death) Last | Due to (or as | a consequence of): | | | | 1 |
| nding use e | N/u | | d | | | | | |
| igned by the attendir be detached for use | Physician/M | Part II. Other significant conditions co | atributing to death but not resulting | on In the underlying cau | use diven in Pert I | 23h Did toh | acco usa conf | tribute to the cause of de |
| by th | hys | 3 | | ig in the dilacitying out | grow are are | | | 3 □ Probably 48 Unk |
| peng peng | by F | | | | | | | |
| peen s | Completed | | | | | 24a. Was en perform | | 24b. Were eutopsy findin available prior to completion of cause of death? |
| ate hes | E O | | | | | 1 ☐ Yes | 2 1 No | 1 ☐ Yes 2 ☐ No |
| | Be (| 25. Was case referred to medical examiner? | | | 26. Place of De | ath (Check only one |) | |
| this certific | To | 1 ☐ Yes 2 ☐ Mo | | /Outpatient 3□ DOA | - | lome 5 Residen | ce 6 Other | r (Specify) |
| h. After th funera | | 27. Manner of Death 1 ☑ Natural 5 ☑ Pending | 28a. Date of Injury (Month, Day Year) 28 | Injury | c. Injury at Work? | 28d. Describe how | v Injury occurre | ed |
| or deeth. | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | М | 1 Yes 2 No | 201 1 (0) | | 0.10.44 |
| efter deeti Director: I in by the | artif | 4 Homicide determined | 28e. Place of Injury - At home building, etc. (Specify) | e, farm, street, factory, | office | City or Town, | State) | r or Rural Route Number, |
| | edical Ce | (Uneck only 2 Medical Exam) | sician: To the best of my knowled ner: On the basis of examination | dge, death occurred at end/or Investigetion, in | the time, date end plece n my opinion, death occu | o, and due to the cau | use(s) and men e and plece, ar | ner as stated. nd due to the ceuse(s) |
| 4 E 5 | Med | one) 29b. Signature and title of certifier | and manner stated. | | License number | | | (Month, Day, Year) |
| Ibin 24 Ibin Fu | | 1 0 0 | 11011 | | | 29 | 2/10 | 150 |
| within 24 hours To the Funeral | | 19-0- 14 | AN UN | | | | | |
| within 24 | | > Burilo | wing | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 7 2 6 2 5 0 | | , , , | / |
| within 24 | | 30. Name and address of person who co | ompleted cause of death (Item 23 | Ba) (Type, Print) | 26256 n Blvd | Baltin | iore | MO 2123 |



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| The street and Number 10st Street and Number 10st Zep Code 10g Calzen of What Country 1420 Trappe Road, 21154 U.S.A. 11. Marital Status 12. Was Duadent Even in U.S. 13. Was Duadent Cherin (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (South Year or Notification of Capper (Capper) (Capper) (South Year or Notification of Capper (Capper) (Capper) (South Year or Notification of Capper (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (Capper) (| | Usual Residence of Decedent | | | 100 | City Town or I | Location | | | | | | 1 | Od tasida City Li |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 30 FEDRUARY 12, 2000 pocation of Deeth 4c. County of Deet ens /Medical 4a. Fecility Name (if not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Baltimore Crty General naryland If Under 24 Hrs. 8. Hours Min. 5. Social Security Number If Under 1 7. Age (In yrs. last birthday) Dirthplace (State or Foreign -292 1□M 21 F Months Days 217-22-292 Usual Residence of Decedent Director Yrs. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mentel Hyglena. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be not the as Maryland 1 XYes 2 No Director nor 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 804 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced America J10. Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) C 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type, Print) 20b. Placa of Disposition (Name of the place), crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Febility 21. Signature of Funeral Service Ocenses Joseph 2222 U Hom inera 2222 W.North Ave.

ass. or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

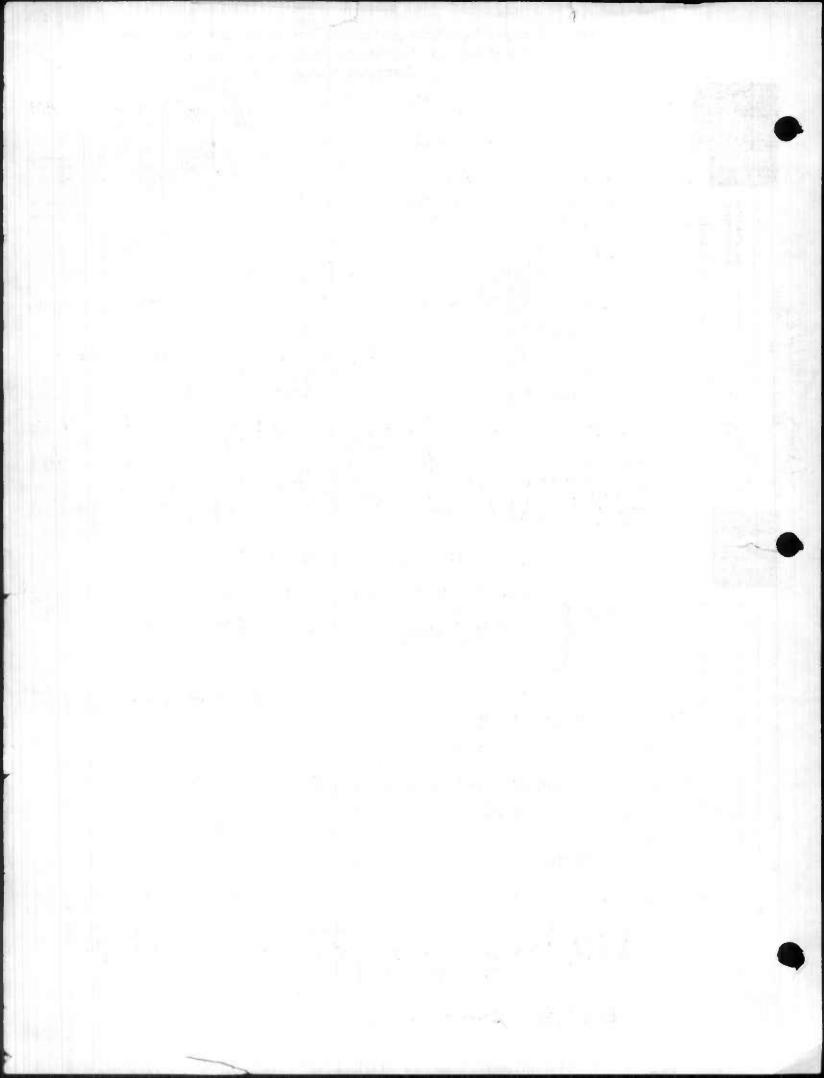
List only one cause on each line. Balto. M Approximate Interval Between Onset and Deeth **Physician** 7Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Causa (Disaase or injury that initiated evants rasulting in death) Last and Records, P.O. Box 68760, the the ŏ रिवर II. Othar significant conditions contributing to death but not rasulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of seath? 1 Yes 2 No 4 Unknown 3 Probably Be Completed by 24b. Were autopsy findings available prior to page 2 should 24a. Was an autopsy peen completion of cause of death? this certificate has 1 Ves 2□ No 1 NYes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complataly filled in by the funeral director, I 25. Was cese raferred to medicel axaminer? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred 5 Pending investigation 1 Natural 1 Tes 2 🗆 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, deta and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 00 30. Namaiand addrass of person complated ceuse of death (Itam 23a) (Type, Print) Jaky land 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

FEB 1 9

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bryan Elizabeth QUID 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Cristield, Maryland necleady Somerset If Under 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 72-557 55 Yrs SC 10:12. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No SAlisbury Moryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Glana Ave 1502 21801 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Unite 1 Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physical Therap health 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Jones James W. Brvan 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kuth Gill SAlisbury Mary brd 21801 - dwalter Sunn 20s. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata crematory or other place. 1 ☐ Burlai 2 ☐ Cremation 3 ☐ Removal from State Britimore MD, 21201 4 ☐ Donetion 5 ☐ Other (Specify) USS W. Boltmure 21. Signature of Funeral Service Licensee Joseph B. Van Sant 22. Name and Address of Facility Research Bldg. 23a. Part Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediate Causa (Final disease or condition resulting in daath) Metastatic Cancer Lun Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 0 No 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical examiner? 26. Piace of Death (Check only ona) Hospitei: 1 Nnpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manger of Death 28b Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Maturai 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

attending physician and for use as the burial-transit the death certificate be executed Box 68760. P.O. 2 Division of Vital Records, page 2 or Attending Physician: funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, tra Medical Exams not man applicable.

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

Funeral Director

Completed by

Be

10

with the Maryland

Physician/Medical Examiner by Completed Be Certification: To edical

State Registrar

1 Certifying Physictan: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 48098

29d. Data signed (Month, Day, Year)

30. Name end addrass of parson who compiated causa of daath (Itam 23a) (Typa, Print)

Highway Cristeld, UD. 21817 201 bunathon

31. Date filed (Month, Day, Year)

29b. Signature and title of certifian

4 Homicida

29a. Certifier (Check only one)

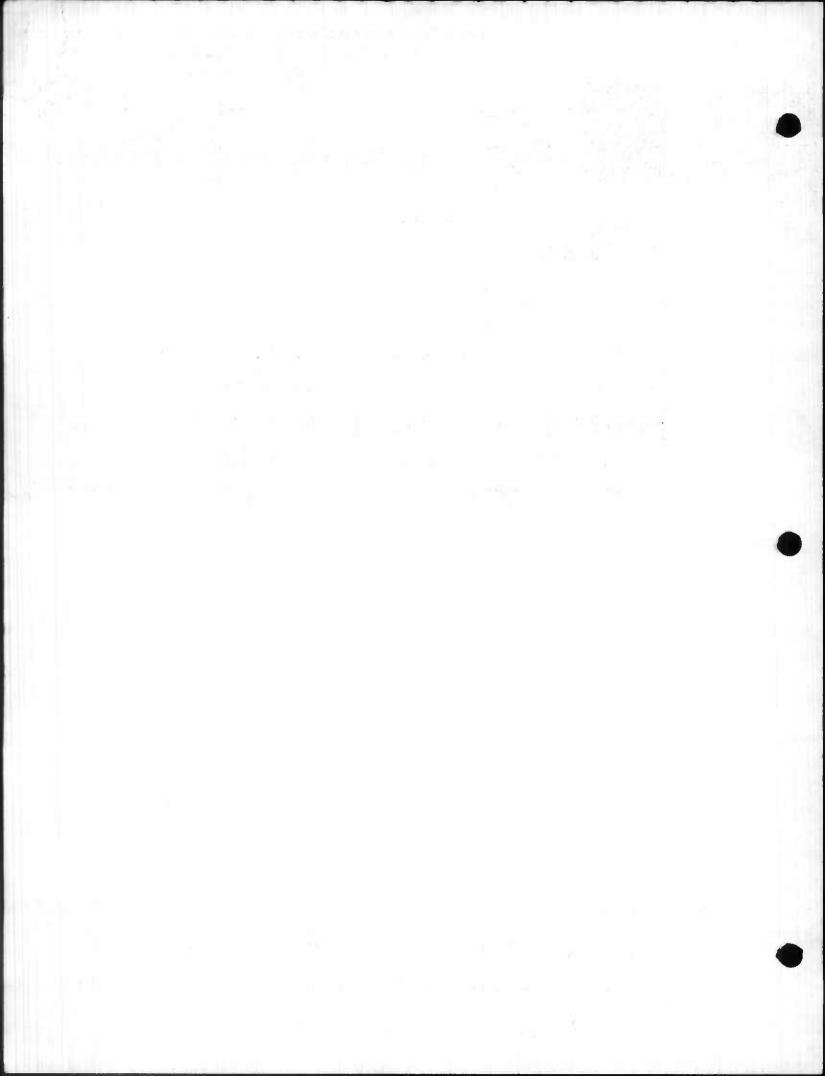
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32. Registrar's Signatura

DHMH 16 Rav 6/95

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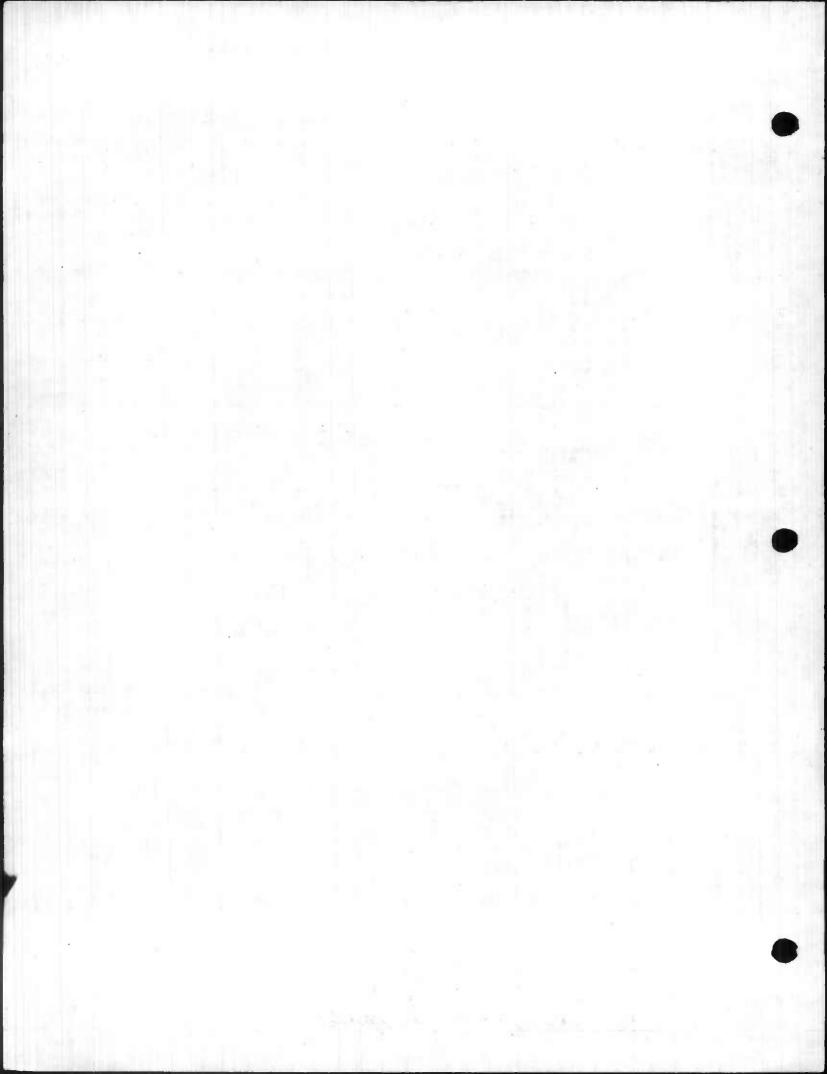


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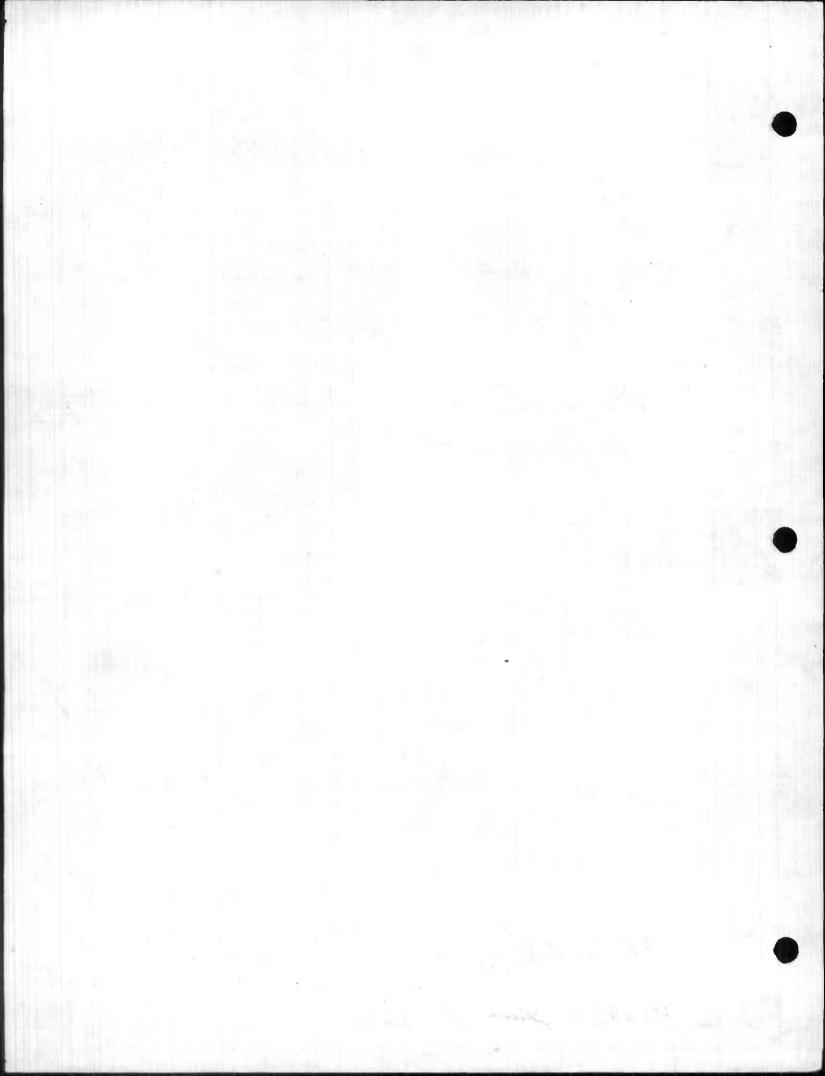
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0949 URORA HAGEGGORGE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) **Examiner** WAShington
5. Social Security Number Age (In yrs. last birthday) If Under 1 Year Months Days Advent Park Montgomery Takoma 8. Dale of Birth (Month, Day) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours 1 M 2 215-16-7822 MD Director Usual Residence of Decedent the Maryland 10e. Slete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show treumstic event, the Medical Examinar must be notified at 1 Yes 2€ No Director Columbia MD Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21044 10799 Hickory Ridge Rd Funeral deeth 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritei Stelus Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiena. I have 21 is marked other than "natural", or feel any Injury or other treumatic event. The permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permits of the permit 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: white ٥ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) unknown Elementary/Secondery (0-12) claims supervisor social security adm 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antonio Fernandez Consuelo Bajen 0 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John Hagegeorge/son 1218 Redcliff Rd Catonsville, MD 21248 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Joseph B. Van Sany Baltimore, MD 21201 Part | Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical VENTRICULAR HOURS Examiner HOURS MONARY SUFFT sician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician at the buriel MASSING HOURS Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed SEVEREMITRAL certificate has MORBIS OBESITY 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Phi within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only 29b. Signature and the of certifier 29c. License number 29d. Dete signed (Month, Day, Year) aller all 18551 MA 30. Number and address of pursion who completed cause of death (Item 23a) (Type, Print)
SAMIR NEMAT, MD, 7610 CARROLL AKOMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 18 Registrar

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| C | Al Al | KT AM 1EN | Please Please END ITEMS: #23 PAR D ITEMS: #23 PART #19b PER F.H. G780 2-19 | Type or Print In BI | ack Indelible Inl វុក្សគ្គក្នុក្សក្តិស្រី Certificate of | c. Assure A | II Copies Are Mental Hygiend | Legible. | 15345 |
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| | /Medic | al | 4a Facility Name (If not institution, give | IMBLE J | <u> </u> | 4b. City, Town, or L | FEBRUARY | 14 2000 County of Death | 4:47 A |
| | Examir | er | | PITAL | | BALTIMORE | | NIA | |
| | Funeral Director | | 5. Social Security Number 2 2 2 - 57 - 9554 Usuel Residence of Decedent | 7. Age (In yrs. las | Yrs. If Under 1 Yea Months Days | | 8. Date of Birth (Month, Day, Yeer DCC.) | 99 Ma | place (State or Foreign intry) |
| | Maryland of ahow | 20 | 10a. Stete 10b. County | 10c. City, | Town or Location | | | | 10d. Inside City Limits 1 (XYes 2 ☐ No |
| | with the Maryle ta or 28s-f short the notified at | Director | 10e. Street and Number | 1 0 | 101. Zip Code | | 10g. Ci | itizen of What Cou | |
| | £ % | eral D | 532 N. Arl | 11011011 | 2. 2/0 | 223 | | U.S. | H |
| 5-0020 | or its | by Funeral | 11. Marital Status 1 \(\) Never Merried 2 \(\) Merried 3 \(\) Widowed 4 \(\) Divorced | 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 13. Was Decedent of If Yes, specify Cu | | o Rican, etc.) | Black, White | |
| 21215-0 | y within 72 jiene. r then "ner | Completed | 15. Decedant's Edi (Specify only highest grad | | 16a. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir | e during most of world | king 16b. H | (ind of Business/Ir | ndustry |
| Maryiand | d 2 should be filed th end Mental Hygie 7 le marked other treumatic event, the | To Be C | 17. Fathar's Name (First, Middle, Last) | nble Sr. | | Doro | 111000 | Alsto | n |
| Baltimore, Mar | of Heal | | 19a. Informent's Name/Ralationship (7) S. Dorothea 20e. Method of Disposition 1 Buriel 2 Cramation 3 II 4 Donetion 5 Other (Specify | A STON 20b. Plac cerr | 19b. Mailing Address (Street 532 Amount of Disposition (Name of Disposition (Name of Disposition of Other plants), crematory or other plants (Name of Disposition of Other plants) | rlingtor | Ave, E | or Town, Stata, Zi | 1d=2/226 |
| Balti | pemit. Page Department of Important: If any Injury or once. | | 21. Signature of Funerel Service Licent | 11111 | 22. Name and Add Joseph L | ress of Facility | Funeral | Home Md 2 | 1216- |
| | Physician /Medical Examiner | | 23a. Perf. Enter the disease, or comp shock, or heen tellura. List only of Immedieta Cause (Finel disease or condition rasulting in deeth) | SUDDEN UNEXP EVIDENCE OF | ECTED DEATH FEMUR BONE (| IN INFANCY | WITH | YE INJUR | Approximate Intervel Between Onset and Death |
| | secuted and al-transit | Examiner | Sequentially list conditions, if any, leading to immediate | b. Due to (or a | s a consequence of): | | | 1 | |
| Box 68760, | eath certificate be axex attending physician ar i for use as the burleI-I | Physician/Medical | causé. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last | cDue to (or e. | s a consequence of): | | | 1 | |
| , P.O. | by the tachec | by Physicia | Pert II. Other algnificant conditions co | ntributing to death but not resulti | ng in the underlying cause g | given in Part I. | 23b. Did tobacco | | to the cause of death? |
| Records | been s | Completed b | | | | | 24a. Wes an auto performed? | 6 | Vera autopsy findings vailable prior to ompletion of cause I death? |
| = | The page | | | | | | 1 Yes 2 | 2□No 1 | Yes 2 No |
| Vital | Physician: this certific ral director. | To Be | 25. Wes case rafarred to medical examiner? 1 🏋 Yas 2 🗌 No | Hospital: 1 Inpatient 2 EF | VOutpatient 3□ DOA O | thec | th (Check only one) ome 5 Residence | 6 □Other /Spec | i(h/) |
| ion of | After the | ation: T | 27. Manner of Death 1 Netural 5 Panding 2 Accident Investigation | | 3b. Time of lnjury 28c. Inj | | 28d. Describe how inju | | .,, |
| Division | To the Hospital or Attending Phantin 24 hours after death. Jahre Funeral Director: After the completely filled in by the funeral | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At home building, etc. (Specify) | a, farm, street, fectory, office | • | 28f. Location (Street a City or Town, Stat | | al Route Number, |
| | Hosp 24 hot Funer etsky fil | edical | 29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exami | sician: To the best of my knowle ner: On the basis of examination and manner stated. | dge, death occurred at the a and/or investigation, in my | time, date and place, opinion, death occur | and due to the cause(s med at the time, data an | s) and mannar as d place, and due | stated. to the cause(s) |
| | To the Table | Me | 29b. Signeture and little of certifier | Wid - | | c.M.E | | ate signed (Month) RUARY 1 | Day, Year) 4,2000 |
| | 111/ | X | 30. Name and address of person who co | | | nn Street | Baltimore | . Marvla | nd 21201 |
| | Sta Registra | | FEB 1 9 2000 | "32. Registrar's Signature | | | | ,, | to A.G.V.A |



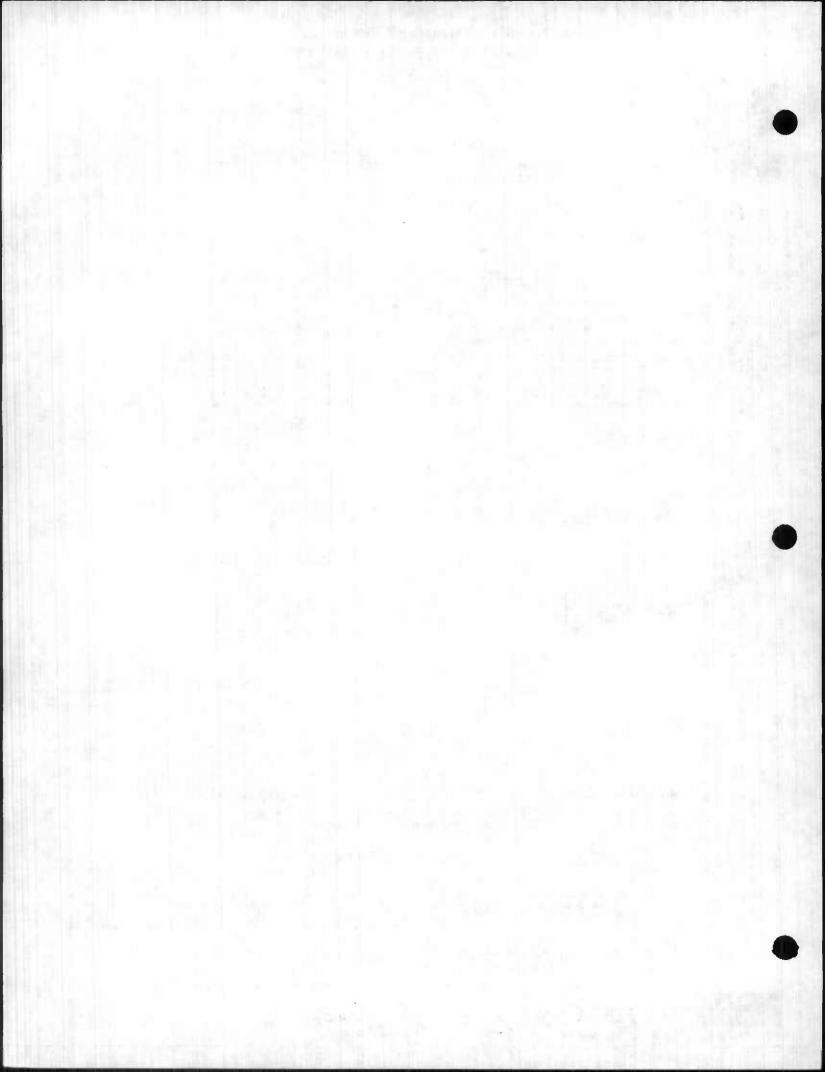
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

| | 1. Decedent's No | ame (First, Midd | lle, Last) | | | | | tificate of | | 2. Dete of | | , No. | | 3. Time of Death |
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| dical iner | 4e Facility Neme | e (If not institutio | on, give s | treet end no | um <i>ber</i>) | | | | 4b. City, Town, or | | | 4c. County | | 11.50 11.1 |
| | 1840 | Westpha | ul St | treet | A | partm | ent 1 | | Baltim | | | N/ | /A | |
| al or | 5. Social Security unknown | y Number | 6. Sex 1 □ | M 2⊠F | 7. Age | e (in yrs. las 85 | st birthday) Yrs. | Months Deys | | | Birth Day, Y | (ear) | 9. Birthp Coun | olace <i>(State or Foreig</i> n ntry) unknown |
| | Usual Residence | of Decedeni 10b. County | | | | 10c City | Town or Lo | cation | | | | | 1 | Od. Inside City Limita |
| tor | MBa. State | N/ | A | | | | ltimo | | | | | | | 1 N Yes 2 No |
| Director | 10e. Street and I | | | | ,, | | | 10f. Zip Code | | | 10g | . Citizen of W | /hat Cour | ntry? |
| era | 1840 11. Meritel Stetu | Westpha | - | | | Ever in U,S. | 13 V | Ves Decedent of I | | Specify Yes or | No- | USA Race | - Americ | can Indian. |
| by Funeral | 1 Never M | s unknov arried 2 Mer d 4 Divorced | rried | Armed F 1 Yes If Yes, G Year or I | Forces? 2 D N Siva A | | | Yes, specify Cub | Hispanic Origin? (ben, Mexican, Pue Specify: | rto Rican, etc.) | | 5100 | k, White, whi | 010. |
| | (6) | 15. Deceder | nt's Educ | ation | 41 | | 16e. Deced | lent's Usuel Occu | pation | orkina | 16 | 6b. Kind of Bu | siness/Inc | dustry |
| aumstic event, the Medical Exami To Be Completed by F | The second second | pecify only higher scondary (0-12) | sst grade | College | | i+) | (Give kind of work done during most of work life. DO NOT use retired) | | | | | | | |
| | unkno | wn | | unl | know | m | u u | nknown | | unkn | (OWI) | | | |
| | | 17. Father's Neme (First, Middle, Last) unknown | | | | | | 18. Mother's Na | me (First, Mid | dia, Ma | aiden <i>Sühl</i> ähl | 9) 11 | | |
| | - | | | | | | | A.I. (7: | unknown Idress (Street and Number or Rural Route Number, City or Town, State, Zip Co | | | | | 0.41 |
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| ther tra | 20e. Method of D | | | | | 20b. Plac | ce of Dispor | 1 Penn S sition (Name of | | more, M | | 21201 oc. Location - | City or To | own, State |
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| any injury anse. | | | | | | | | | | | | | | |
| | 21. Signature of | Funeral Service | House | Van | Sant | t_ | St. | Name end Address | ess of Facility Lomy Boar | d 655 | W. 1 | Baltim | ore S | Street |
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State of Maryland / D

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| Certificate of Death | Reg. No. | | 0001 | |

| | Physician |
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| 1 | /Medical |
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Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be find Department of Health and Memtel Hy Important: If Nem 27 is merked offer any injury or other treumetic event, acts injury or other treumetic event.

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be exe within 24 hours after death.

To the Funeral Director: After this c

Division of Vital Records, P.O. Box 68760,

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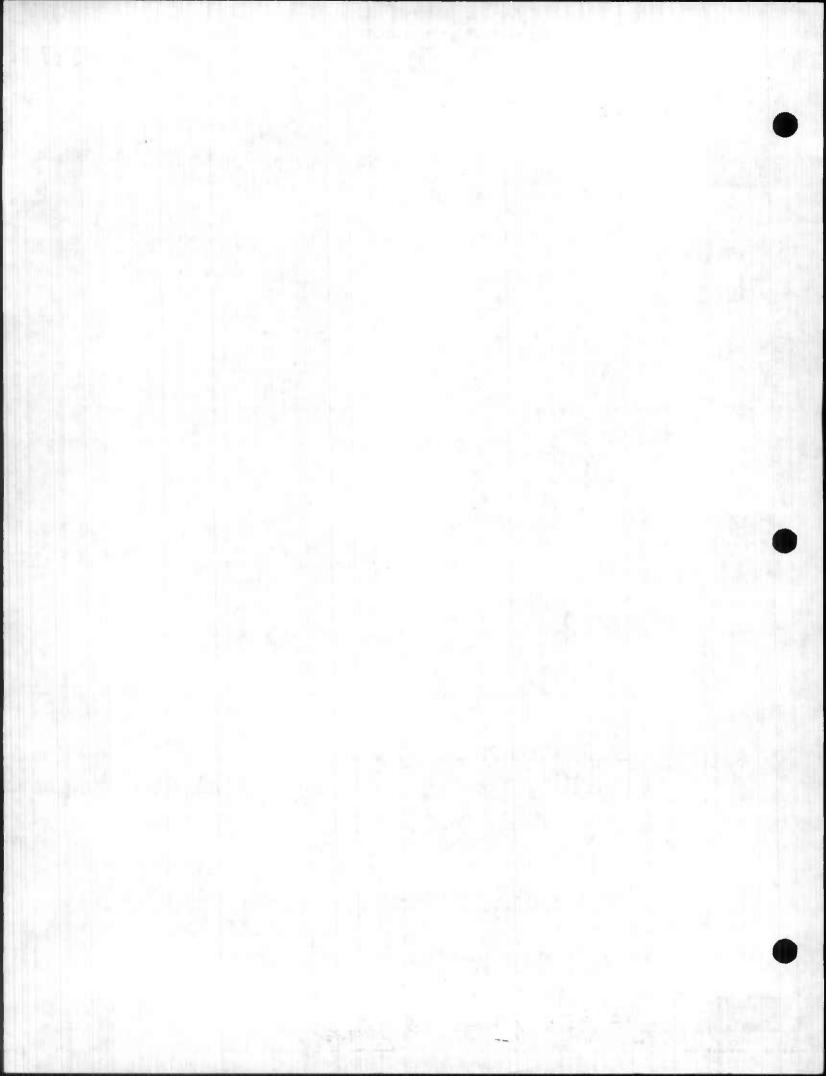
Strphan S. Radentz 111 P

31. Date filed (Month, Dev. Year)
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Separate

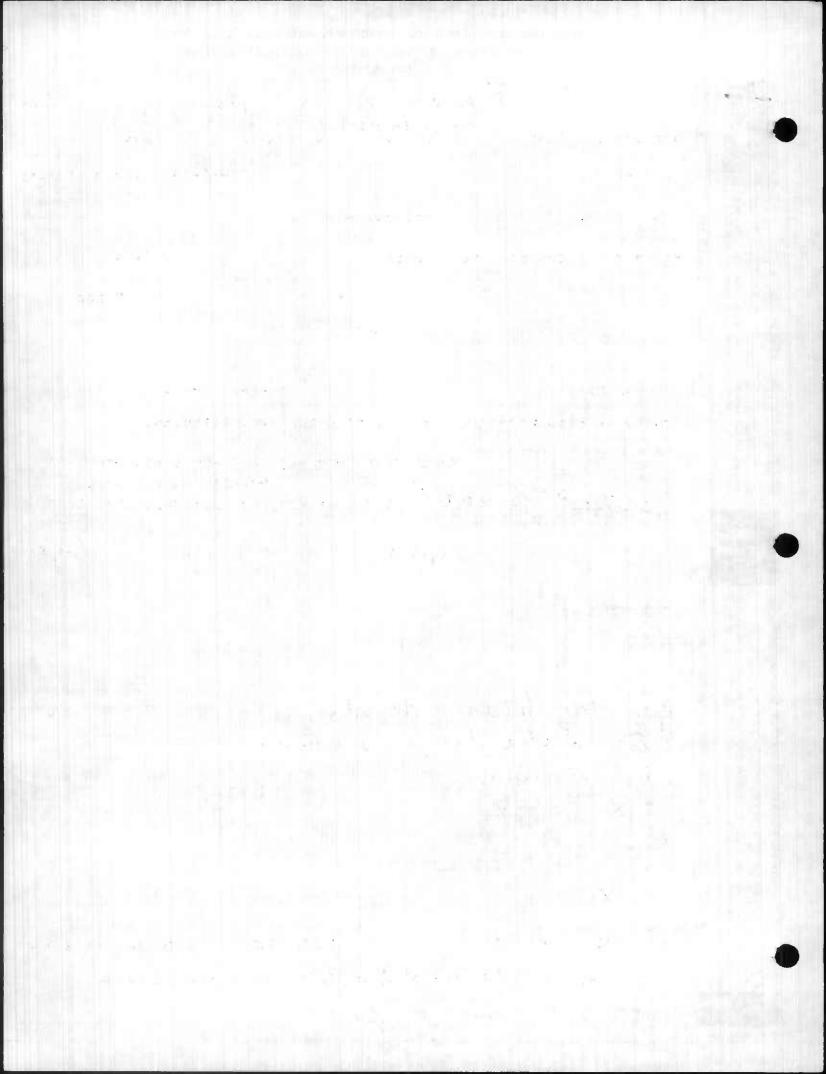
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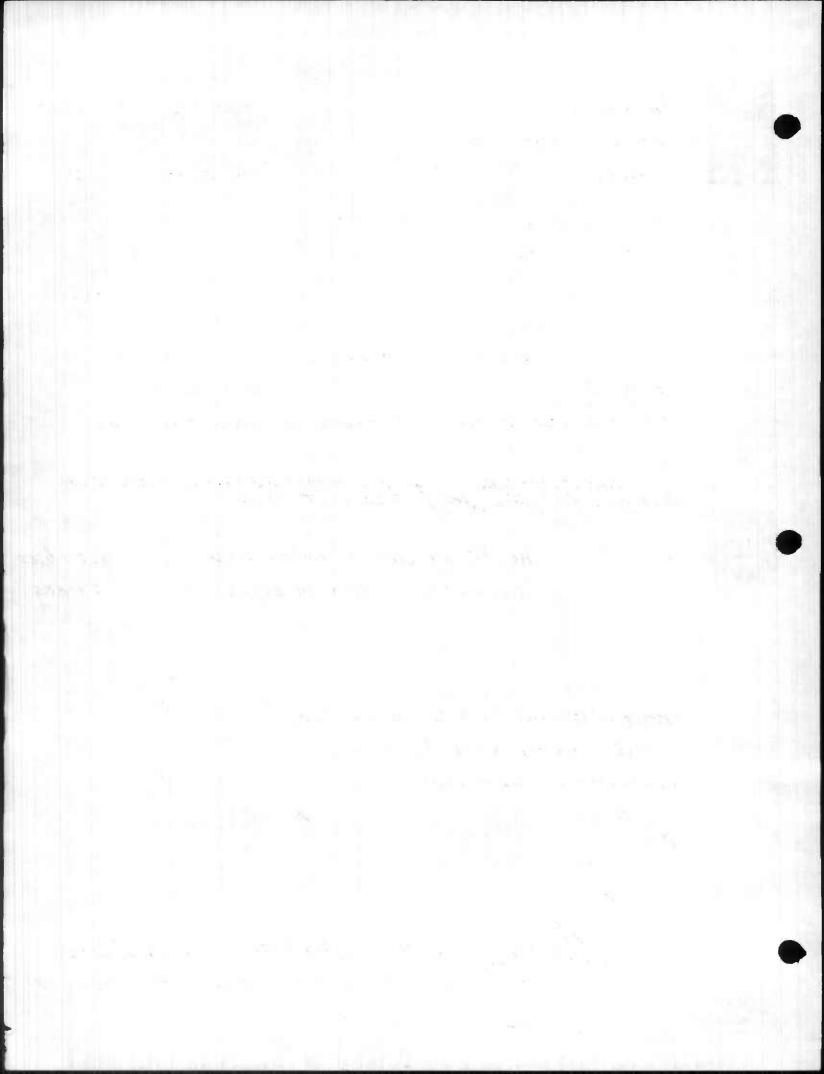
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death Reg. No. 0 05348 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician //Medical | 1. Decedent's Name (First, Middle, Last) Pearlene Powers 2. Date of Death Fe Daumy 15, 2000 5 5/Am |
| Examiner | 4a Facility Nama (If not institution, give street and number) Mercy Hospital—4b. City, Town, or Location of Death Harbour Inn Convalescent Center Baltimore N/A |
| Funeral Director | 5. Social Security Number 2.1.3-36-81.07 6. Sax 1 Months Days Hours Min. 7. Aga (In yrs. last birthday) Yrs. 8. Data of Birth (Month, Day, Year) (Month, Day, Year) 0.9-1.6-1.4 9. Birthplaca (Stata or Foreign Country) SouthCarolina |
| death with the Marylend ms 23e or 28e-f show cross be notified at | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 |
| with the M a or 28a-f Lbe notified | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. |
| _ p 22 E | Harbour Inn Convalescent Center 11. Marital Status 12. Was Decedant Evar in U.S. Amed Forces? 1 Navar Married 2 Married 3 Widowad 4 Divorced 12. Was Decedant Evar in U.S. Amed Forces? 1 Yes, Specify Cuban, Maxican, Puerto Rican, atc.) 1 Yes 2 No Specify: Black |
| ed within 72 hours ygiene. Nor than "natural", It me Medical | 15. Decedent's Education (Specify only highest grada completed) Elemantery/Secondary (0-12) Collega (1-4or 5+) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry |
| Maryland 21215-0020 d2 should be filed within 72 hours et th and Mental Hygiene. 7 Is marked other than "natural", or traumatic event, the Medical Exam To Re Completed by 8 | 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Thomas Gilmore 19a. Informant's Name/Ratatlonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routs Number, City or Town, Stata, Zip Code) |
| | Arcuabelle Barber/Cousin 927 N.Arlington Ave. Balto.Md. |
| O STORE | 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata |
| Baltim permit. Pe Departmen Important: any Injury | 4 Donation 5 Other (Spacify) Mount Zion Cemetery 2-21-00 Landsdowne, Md 21. Signatura of Funaral Sarvica Licensae 22. Nama and Addrass of Facility Howell Funeral Home |
| Ba perm Depa Impo any l | 4600Liberty Hghts. Ave.Balto.Md.21207 |
| Physician | 23a. Pari T. Enter the distance, or complement one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. |
| /Medicai Examiner | Immediata Causa (Final disaase or condition resulting in death) Dua to (or as a consequence of): |
| 60, be executed ician end buriel-transit | Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or injury that initiated avants Due to (or as a consequence of): Due to (or es a consequence of): |
| 687 flicate phys as the | Cause (Disease or injury that initiated avants resulting in death) Last Due to (or es a consequence of): d. |
| P.O. net the d d by the detached | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Respiratory thiure dewenta, 1 Yes 2 No 3 Probably 4 Denknown |
| Records, P he law requires that e has been signed b age 2 should be deter | Cerebro VAS WIAR disease hypertermin, 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? |
| al Ricate he icate he r. page | diabetes mellitus 10 yas 20 No 10 yas 20 No |
| of Vita Physician: this certific ral director, | 25. Was casa referred to medical axaminer? 1 Yas 2 No |
| on o ding Ph th. After th funeral | 27. Manper of Daath 1 Describe how injury occurred (Month, Day Year) 28a. Data of Injury 28b. Time of injury Work? 2 Accident investigation 28a. Data of Injury 28b. Time of injury Work? 1 Yes 2 No |
| Division of Vital Reconstruction of Attanding Physician: The law make hours after deeth. Funeral Director: After this certificate hes principled filed in by the funeral director, page 2 edical Certification: To Be Comp | 3 Suicida 6 Could not be datarmined 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) |
| Hospital of the Hours a Funeral Distely filled dical Ce | 29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. |
| To the withing the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of | 29b. Signatura and title of certifier Juliup 29c. Licensa number 29d. Data algned (Month, Day, Year) February 15, 2000 |
| XX | 30. Name and address of person who completed cause of death (Itam 23e) (Type, Print) New 1 odd 301 St Paul Place Balt more 2/202 |
| State Registrar | 31. Data filad (Month, Day, Yaar) 32, Registrar's Signature |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | | | | | of Maryla | | artment of F rtificate of | | nd Mental Hy | giene () Reg. No. | 0 | 5349 | |
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| | /Medi | | MARY RENSHAW | | | | | | FEBRUAF | | 000 | 19:15 PM | |
| | Exami | ner | 4a. Facility Name (If not institu | | | | | 4b. City, Town | , or Location of Deet | h 4c. County | of Death | | |
| | | | Calvert Mand | | | | | Rising | | | cil | | |
| | Funeral Director | | 5. Social Security Number 218-16-6078 | 6. Sex 1 ☐ M 2 💢 F | | 93 Yrs. | If Under 1 Year Months Days | | Min. 8. Dete of Bi (Month, Di Aug 26 | | 9. Birthi Cou | place (State or Foreign ntry) DE | |
| | pur * | | Usual Residence of Decedent 10e. State 10b. Cour | ntv | 100.0 | city, Town or Lo | cetion | | | | | Od. Inside City Limits | |
| | sho | 2 | A1,1100. | Cecil | 100.0 | | | | | | | 1 ☐ Yes 2√ No | |
| | the A | ect | MD 10e, Street and Number | Cecii | | KIS. | ing Sun | | | 10g. Citizen of | Mh at Cau | | |
| | ath with the Marylan 23a or 28a-f show | 급 | 1881 Telegra | nh Poad | | | 21911 | | | US | | ntry ? | |
| | e 23 | eral | | T | ecedent Ever in I | 110 123 | | tionania Orlain | 2 (Sacati Vac as N | | | can Indien, | |
| 250 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at | by Funeral Director | 11. Meritel Stetus 1 Never Merried 2 M 3 XWidowed 4 Divorce | arried Armed | Forces? s 2 🕅 No Give | | was Decedent of P f Yes, specify Cub 1 ☐ Yes 2X No | an, Mexican, F | ? (Specify Yes or No Puerto Rican, etc.) | | ck, White, | | |
| Ş | 2 hou | | 15. Deced | ent's Education | | 16a. Deced | dent's Usual Occup | petion | | 16b. Kind of B | usiness/In | dustry | |
| 0200-61212 | hin 7 | Completed | (Specify only hig Etementary/Secondery (0-12 | hest grade complete | · | (Give | kind of work done DO NOT use retire | during most of | f working | | | | |
| 7 | d with | EO | 12 | none | (1-4or 5+) | | bookeepi | no | | unkn | OWn | | |
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| Maryland | should be nd Mental marked o | To B | Edwin Hopper | | | | | i I | Laura S | tafford | | | |
| 2 | d 2 should it and Men 7 ie market traumatic | - | 19a. Informant's Name/Relation | nship (Type, Print) | | 19b. Maitir | ng Address (Street | end Number o | or Rural Route Numb | | Stete, Zij | Code) | |
| | true true | | Calvert Man | or Nursing | g Home | 1881 | Telegrap | h Road | Rising, | Sun, Md | 219 | 911 | |
| Dairingle, | Pages 1 an nent of Heali nt: if Item 2 iry or other | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetio 4 ☒ Donetion 5 ☐ Other | | 20b. m State | | sition (Neme of natory or other ple | | Date | 20c. Location | | own, State | |
| מפוב | permit. Pages I Department of H Important: if its any injury or ot pnce. | | 21. Signature of Funeral Servi Joseph | B Van Sa | ent L | | State Anatomy Board 655 W. Baltim Baltimore, MD 21201 | | | | | more Street | |
| | Physician /Medical Examiner pur appropriate pur purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply purply pur | l Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 6. AC | Due to | (or as e consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence of consequence | RDIAL (puence of): RTERY puence of): | infar Dise | RCTION CASE | | | Onset and Death O MINUTE SYEARS | |
| 200 000 | death certificate be exe e attending physician a ed for use as the burial- | Physician/Medical | Cause (Disease or injury that Initiated events resulting in death) Last | d | Due to (| or as a conseq | uence of): | | | | | | |
| į | the day | sic | Part II. Other significant cond | tions contributing to | death but not re | sulting in the u | nderlying cause given | ven in Part I. | 23b. Dld | tobacco use co | ntribute t | o the cause of death | |
| | gned b | by | CHRONIC C | BSTRUC | TIVE . | LUNG | DISEA | SE, | 10 | Yes 22 No | 3 □ Pro | bably 4 Unknow | |
| חברטומא, | 2 S S | Completed | COMPLETE | HEART I | 3 LOCK | PIERM | MANEN | 7 | | an autopsy ormed? | av cc | dere autopsy findings vallable prior to empletion of cause death? | |
| | E as a | S | PACEMAKE | R. DE | MENT | IA | | | 10 | Yes 2 No | 11 | ☐ Yes 2☐ No | |
| | ysiclan: The s certificate director, pag | Be | 25. Wes case referred to medi examiner? | | | | | | Deeth (Check only | one) | | | |
| 5 | Physician: this certific ral director, | ို | 1 ☐ Yes 2 No | Hospitel: 1 [| Inpatient 2 | ☐ ER/Outpatien | | 4 Nursi | ng Home 5 ☐ Res | | | (y) | |
| | ding P. h. After t funera | lon: | 27. Manner of Death 1 Netural 5 □ Pen | ding (Mo | te of Injury onth, Day Year) | 28b. Time of Injury | Wo | ryet rk? IYes 2 ⊡ No | The Month | how injury occur | red | | |
| | or Attendent offer deat offector: in by the | ertification: | 3 ☐ Sulcide 6 ☐ Cou | rmined 289. Pla | ce of Injury - At I Iding, etc. (Spec | | M 1 == | 1165 2 100 | 28f. Location | Street and Numb wn, State) | ber or Run | al Route Number, | |
| | To the Hospital or Attent within 24 hours effer deat To the Funeral Director: completely filled in by the | edical C | 29a. Certifier (Check only one) Certific | ring Physician: To the al Examiner: On the and ma | he best of my kn basis of examin anner stated. | owledge, death ation and/or inv | occurred at the time time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occurred at the time occu | me, date and popinion, death | place, and due to the occurred at the time, | cause(s) and madate and place, | anner as s and due t | steted. o the cause(s) | |
| | To th Vithii To th | M | 29b. Signeture end title of certi | liey/ | | _ | 29c. Licens | | | 29d. Date signe | | | |
| | .12 | | 30. Name and address of person | welle | Mylan | MAD THE | Print) | 4534 | 14 | 02/1 | 13/2 | 2000 | |
| | Sta | ite | SURESH DI- 31. Date files (Marth, Payo Yel | HANJAN | Registrer's Sign | 6225 neture | S. UNION |) AVE | HAVRE | EGRAC | E, M | 02/078 | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Tima of Desth Henson M Spicer 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D 4c. County of Death Levindale Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 11XM 2□ F Yrs. 212-18-6604 81 08/08/1918 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Dorchester Church Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1918 Liners Road 21622 U.S.A. 14. Rece - American Indian, Bleck, Whita, etc. 12. Was Decedent Ever in U,S Armed Forces? 1 Q4 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1942 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 1945 Specify: Black 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Seafood Company Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Asbury Thomas Spicer Sr. Lillie Mae Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Trout Lily Ct., Owings Mills, Maryland 21117
20b. Place of Disposition (Name of cemetery, cremetory or other place) John | Dete | 20c. Location · City or Town, State Timothy M. Dixon/Grandson 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Wesley U.M. Church Ceme. 02/23/00 Church Creek, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Lipensee Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel thembosi Cerebral disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Funeral

Director

or iberra 23a or 2 aminer must be no

permit. Pages 1 and 2 ahould be filed within 72 hours after o Department of Health and Mental Hygiens. Importants if Item 27 is manked other than "natural", or Item any injury or other traumatic event, the Medical Examina-

Maryland 21215-0020

Baltimore,

Box 68760.

P.O. I

Records,

Division of Vital

the Maryland r 25a-f show Lnotified at

> US0 88 should page 2 funeral director,

Examiner physician end s the buriel-transit The lew requires that the dasth certificate be assecuted Physician/Medical signed by the at d be detached for þ Completed certificate or Attending Physicien: B Certification: To 100 After To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun

adical State Registrar

25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2□ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

29c. License number

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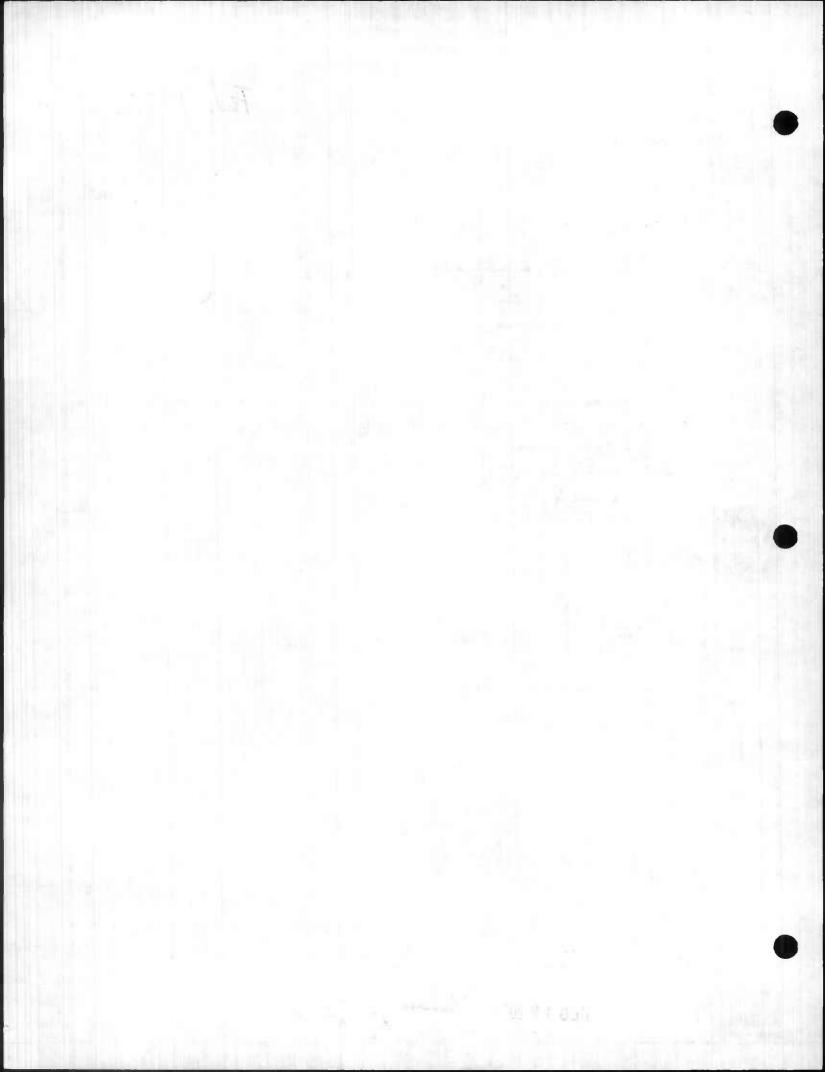
29d. Dete signed (Month, Dav. Year) 00

Miller Kaymond 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymong Millor 31. Date filed (Month, Day, Year) Man Sweet Restestor Smli

29b. Signature and title of certifier

32. Registrar's Signature FEB 19 5008



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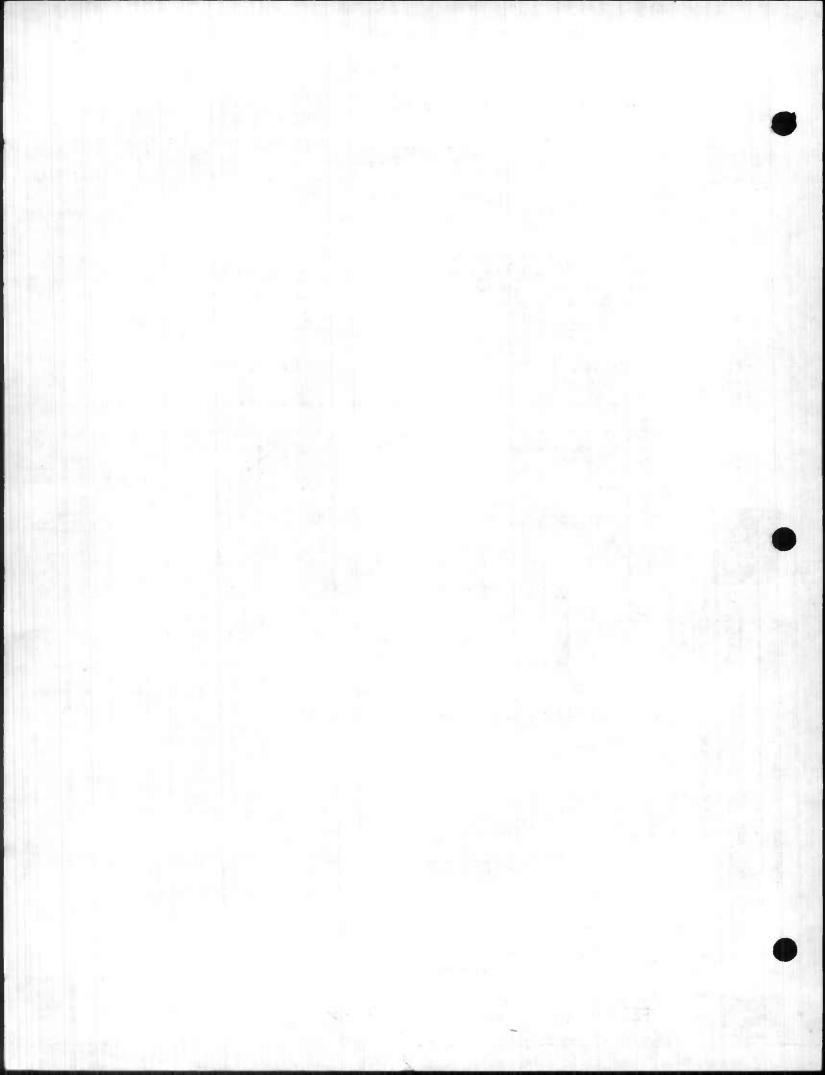
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| | | Certificate of Death | Reg. No. | , , |
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| Physician /Medical | 1. Decedent's Narge (First, Middle, Last) | ON | 2. Dete of Deeth Month Dey Year 5 | ime of Death |
| Examiner | 4s Facility Nating (it not institution, give street end number) | 4b. City, Town, or L | ocation of Death 4c. County of Death TDFD. | |
| Funeral Director | 5. Sociel Security Number 6. Sex 7. Age (in yrs. last 1 M 25/F 91 | t birthday) If Under 1 Year If Under 24 Hrs. Montha Days Hours Min. | 8. Dete of Birth (Month, Dey, Year) 08 - 04 - 09 8. Birthplace (S Country) Country) Country) | State or Foreign |
| pus M | Usual Residence of Decedent 10a. Stete 10b. County 10c. City, 7 | Town or Location | 10d Ins | ide City Limits |
| the Maryland 28s-f show notified at | MD Montgomery CHE | EVY CHASE | 15 | es 2 No |
| 23a or | 5504 MONTGOMERY ST | 101. Zip Code 20815 | 10g. Citizen of What Country? | |
| by L. | 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes, Give Yeer or Detes: | 13. Wes Decedent of Hispenic Origin? (Spit Yea, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify: | ecify Yes or No- Rican, etc.) 14. Race - American Indi Bleck, White, etc. Specify: WI+IT | |
| n 72 hours natural; of elled by | 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of work | ing 16b. Kind of Business/Industry | |
| filed within 72 ho Hygiene. ther then "naturent, me Wedeel | Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown | 'life. DO NOT use retired) surrogate mother | unknown | |
| be filed and other avent, it | 17. Father's Neme (First, Middle, Last) | | e (First, Middle, Maiden Sumeme) | |
| 2 should be and Mentalia marked aumetic events. | James Walker | Margar | et A. Cauld | |
| De 72 | 19a. Informent's Neme/Reletionship (Type, Print) Dorothy Penders/friend | 19b. Meiling Address (Street and Number or Rur 8503 Woodville Rd Mr. | al Route Number, City or Town, State, Zip Code) Airey, MD 21771 | |
| mit. Pages 1 and apartment of Healt mortant: if Ibm 27 my Injury or other to | 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) | e of Disposition (Neme of etery, cremetory or other place) | Dete 20c. Location - City or Town, Ste | ete |
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| /Medical Examiner | Due to (or as | T CEREBRAL VASCULA s a consequence of): SCLEMISSES | | and Death |
| tificate be executed as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | s e consequence of): s a consequence of): | | |
| onding use a | d | | | |
| death cer e attendir ed for use | Pert II. Other algorificant conditions contributing to death but not resulting | ng In the underlying cause given in Pert I. | 23b. Did tobacco use contribute to the co | ause of death' |
| ss that the death cert igned by the attendin be detached for use by Physician/M | | uma Accident | 1□ Yea 2☑ No 3□ Probably | 4 Unknow |
| aw requir | 2 HEMIPLAGIA | | 24e. Wes an eutopsy performed? 24b. Were aut available completic of death? | prior to |
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| yaician: The law is certificate has b director, page 2 s To Be Compli | 25. Was case referred to medicat examiner? | | h (Check only one) | |
| ng Phy frer this meral c | | WOutpatient 3 DOA Other: 4 Nursing Ho Bb. Time of Injury M 28c. Injury et Work? 1 Yes 2 No | ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred | |
| To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1 | 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home building, etc. (Specify) | e, ferm, street, fectory, office | 28f. Location (Street and Number or Rural Route City or Town, State) | e Number, |
| he Hospiu in 24 hours he Funera pletely fille edical C | 29a. Certifier (Chart and Cartifying Physician: To the best of my knowled and control of the basis of examinetion end menner steted. | dge, deeth occurred at the time, date and place, and/or investigetion, in my opinion, deeth occur | and due to the cause(s) and manner as stated. red at the time, date end place, and due to the ca | ause(s) |
| To the within To the comp | 29b. Signeture and the discontinue | 29c. License number | 29d. Date signed (Month, Day, Y | 'ear) |
| | · Wille | MD. 026 499 | 2-15-00 | |
| | 30. Neme and address of person who completed cause of death (Item 23 | sa) (Type, Print) | | |
| State Registrar | 31. Date filed (Month, Dey, Year) FFR 1 8 2000 | & Soort | | |

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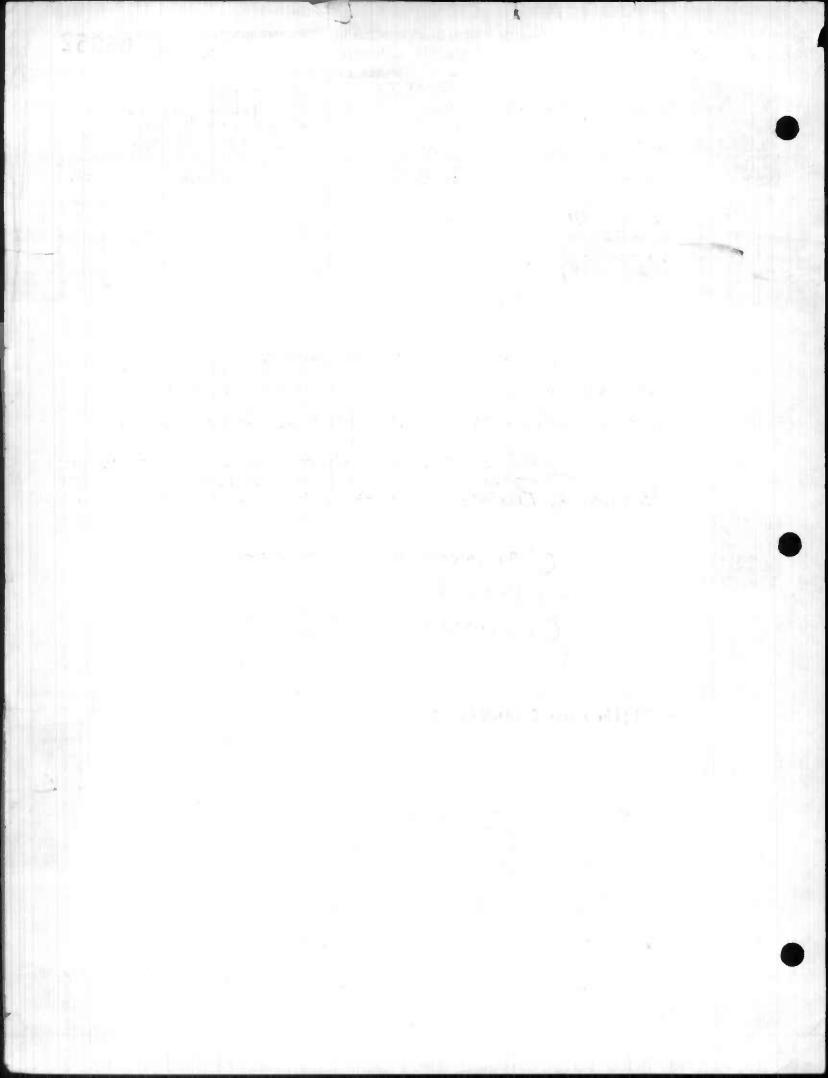
State of Maryland / Department of Health and Mental Hygierical Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Day Vaar **Physician** 7:15 AM ARM STRONG ALBERT February,15 2000 /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BON SECOUR HOSPITAL BALTIMORE N/A If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 1⊠M 2□ F Yrs. Director 248-14-0734 85 3-20-14 N.C. Usuai Rasidenca of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show Y 26a-f show MD. N/A 1 Yas 2 No BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? item 27 is marked other than "naturel", or items 23.8 other traumatic event, the Maulical Examiner must 2591 EDMONDSON AVE. 21223 Funeral USA "ath 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Hasith and Mental Hygiene. Important: If item 27 is marked other than "naturel", or their any injury or other traumatic event, it a Madical Exemptor Black, Whita, atc. 1 Navar Married 2 Marriad 1 ☑ Yas 2 ☐ No If Yes, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: BLACK ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Eiemantary/Secondary (0-12) Coilega (1-4or 5+) -12--0-SHIPMILL ATTENDANT STEEL 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be WILLIAM ARMSTRONG 2 MOLLY McCULLOUGH 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) LULA MAE HARBISON (DAUGHTER) 2114 HARTFORD DR. GASTOININ, N.C. 28052 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (SpacifyENTOMBMENT LOUDON PARK CEMETERY 2-19-2000 BALTIMORE, MARYLAND 21. Signatura of Funeral Service Licens 22. Nama and Addrass of Facility VERNON BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one ceuse on each line. Approximeta Interval Between Onset and Daath **Physician** artinoma of untrawn PRIMART /Medicai Immediata Cause (Final disaasa or condition resulting in daath) Examiner Due to (or es a consequance of): Examiner neumonia burial-transit Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Ceuse (Diseesa or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): and P.O. Box 68760, attanding physician for use as the buria Uro Sep Si S Physician/Medicai 80 Part II. Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? signed by I 1 Yss 2 No 3 Probably 4 Unknown THROMBO (utopenia Records, þ 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed peen The law page 2 certificate 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Wes casa raferred to madical Be 26. Placa of Daath (Check only ona) axaminer? Hospitel: 1 ☐Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 2 1 Yes 2 No this 28a. Data of Injury (Month, Day Year) 27. Mennar of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Aftar 5 Pending invastigation 1 BNaturel To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte complately filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Pieca of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 cartifying Phystolan: To the best of my knowledge, deeth occurred at tha tima, date and piece, end dua to tha causa(s) and manner as stated.

2 Madicat Examiner: On the basis of axemination and/or invastigetion, in my opinion, death occurred at the time, date and piece, and dua to the causa(s) and manner stated. Medical 29a. Certifian 29b. Signatura and titla of certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number R. m. Shar no 1) 0019 668. 2-18-2000 Hospital Balmore. MD 30. Nema and address of person who complated cause of deeth (Item 23a) (Type, Print) .m. SHAH m. 1 Bon Secmy 31. Date filed (Month, Day, Year) FEB 2 2 2000 32. Registrar's Signatura State

DHMH 16 Bay 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Day Year Smil Baker 1115P FEB 2000 18 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death County Greneval Howard Howard Hospita lumbia 0 If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days 1 M OF 218.26.6073 69 July 23, 1930 Maryland **Usual Residence of Decedent** 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Anne Arundel Severn 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Lot 130 7959 Telegraph Road 21144 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Clerk State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Baker Rosalie Muns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2752 Norfen Rd. Baltimore, Md. 21227. Loca of Disposition (Name of 2002). Location Robert Baker/Brother 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 2/23/00 Elkridge, MD 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) Baltimore/Washington Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Gary L. Kaufman Funeral Home eter. 7250 Washington Blvd. Elkridge, Md. 21075 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death unchion Immediate Cause (Finel disease or condition resulting in death) ONGAN Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 3 □ Probably 4 ☑ Unknown 1 Yea 2 No 24b. Wera autopsy findings available prior to 24e. Was an eutopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Daeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

The lew requires that the death certificets be axecuted of Vital Records, P.O. Box 68760. or Attending Physician: To the Hospital or Attending responsibility of hours after death.

To the Funeral Director: After this ce Division

Physician

/Medical

Examiner

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Funeral Director

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Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland narif of Health and Mentel Hyglene.
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Baitimore, Maryland 21215-0020

or other traumatic avent, the Medical Examinar

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Physician/Medical Examiner

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Certification: To

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SANTA 31. Date filed (Month, Day, Year) State Registrar

4 Homicide

29b. Signature and title of certifie

29a. Certifier (Check only one)

> MD Hickory 10805 32. Registrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 16 Rev 6/95

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

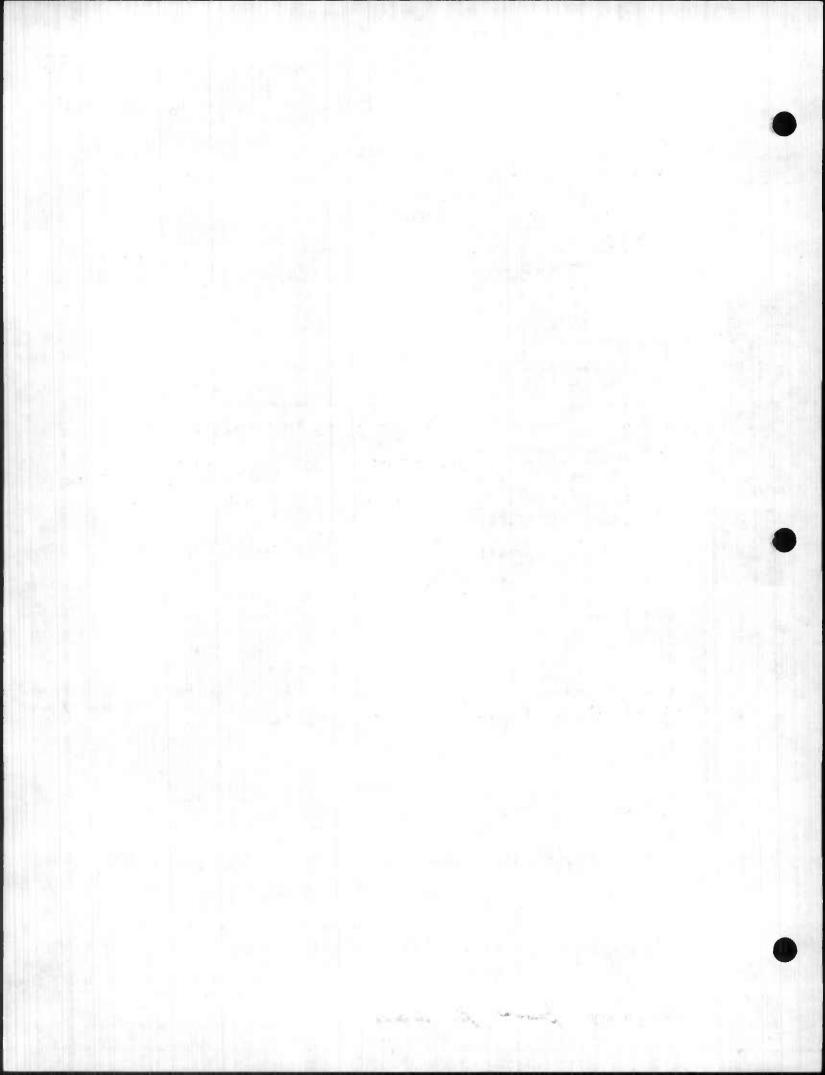
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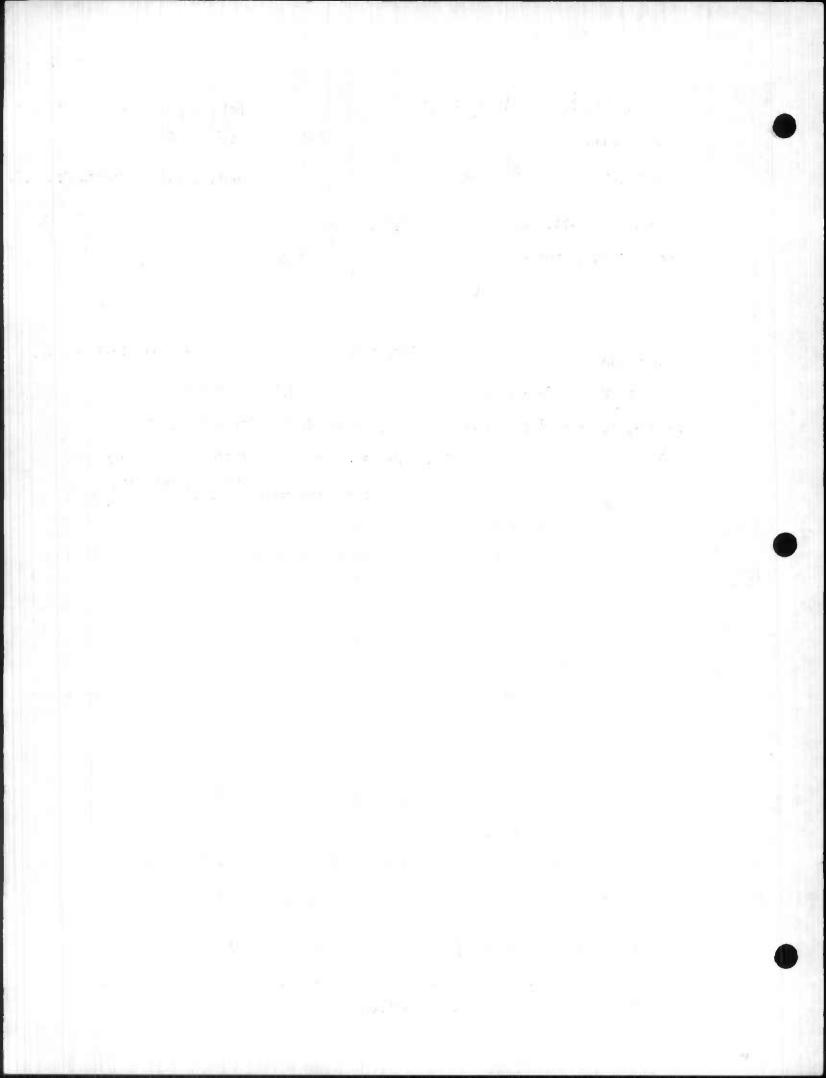
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State of Maryland / Department of Health and Mental Hygien 0 05354

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|-------------|----------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------|---------------------------------------------|-----------------------------------------|------------------------------------|----------------------------------------------------|----------------------------|
| | Physici /Medi | | 1. Decedent's Neme (First, Middle, L | Almqui | st | | | 2. Dete of De Month | Dev | Vees | 45pm |
| | Exami | | 4e. Fecility Neme (If not institution, g. FAIR HAVEN | ive street and number) | | | 4b. City, Town, or SIKES V | Location of Deet | | | |
| | Funeral Director | | | Sex 7. Age (In yr 1□ M 2)(□ F 92 | s. lest birthdey) Yrs. | If Under 1 Yee Months Deys | | . (Month, De | rth ey, Year) , 1907 | 9. Birthplece (Ste Country) Bergen | ite or Foreign |
| | r 28a-f ahow | tor | Md. Balt | imore 10c. 0 | City, Town or Lo | ocation istersto | wn | | | | le City Limits Yes 2 No |
| | th with the 23s or 28 ust be not | i Director | 10e. Street end Number | | | 10f. Zip Code | | | 10g. Citizen of V | | |
| 020 | or Items | by Funeral | 201 Glyndon D 11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Detes: | | Wes Decedent of If Yes, specify Cu | 21136 Hispenic Origin? (Sben, Mexican, Puer | Specify Yes or No to Rican, etc.) | | SA e-American Indier k, White, etc. White | ٦, |
| 21215-0020 | within ane. than | Completed | 15. Decedent's E (Specify only highest g | Education rede completed) College (1-4or 5+) | (Give | dent's Usuei Occi kind of work don DO NOT use retir retery | upetion e during most of wo red) | orking | | siness/industry | n Co |
| nd 2 | be filed withintel Hygiane. | Be Co | 12 Grade 17. Fether's Neme (First, Middle, Las | () | 000 | i c c c i j | 18. Mother's Ne | me (First, Middle | , Meiden Sumem | | 1 00. |
| Maryland | Mer Mer atic | To | Gustav 19e. Informent's Name/Reletionship | Johansson | 10h 84niii | no Addreso (Chro | Hulda | | | Court Tie Condai | |
| Ma | nd 2 lith a 27 is | | Kere H. Averett | (Grandaughter | | Sandtray | etend Number or R Circle | | Pa. 189 | | |
| Baltimore, | Pages nent of mt: If H my or o | | 20e. Method of Disposition 11 Buriai 2 Cremetion 3 4 Donetion 5 Other (Spec | 20b ☐Removel from Stete | Plece of Dispo | osition (Name of metory or other pi 1 Cemete | (ece) | Dete 2/21/00 | | city or Town, Stete erco, Md | |
| Balt | permit. Departments any inju | | 21. Signature of Funeral Service Lice | Elene | | 2. Neme end Add LINE FUN | ress of Facility ERAL HOME | | | stown Roa Md. 2113 | |
| | Physician /Medical | | 23a. Part1. Enter the disease, or con- ock, or heart feilure. List only Immediate Cause (Finei disease or condition | nplications that caused the day one cause on each line. | | | | | arrest, | Approxi interval Onset a | Between and Death |
| | Examiner | ē | resulting in deeth) | 0. | (or es e consec | | | | | | |
| x 68760, | ertificate be executed sing physician and se as the burial-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last | c | (or es e conseq | | | | | | |
| .O. Bo | 0 2 3 | Physician | Part II. Other algnificant conditions | contributing to deeth but not re | esulting in the u | nderlying ceuse ç | given in Pert I. | | | ntribute to the cau | |
| Records, P. | peen | Completed by P | | | | | | 24e. Wes | yee 2⊠No s an eutopsy ormed? | 24b. Were autop svailable pr completion of death? | osy findings |
| al Re | The ate h | Com | | | | | | 10 | Yes 2 No | 1 ☐ Yes | 2(X No |
| of Vital | Physician: The this certificate ral director, pag | o Be | 25. Wes cese referred to medicel exeminer? 1 ☐ Yes 2 ☒ No | Hospitel: | | | Wher | eth (Check only | | | |
| ion of | ng Ph ftar thi | ation: To | 27. Menner of Deeth 1 Menturei 5 Pending 2 Accident investigation | 26a. Dete of Injury (Month, Dey Year) | 28b. Time of Injury | f 28c. Inj | 423(1401511191 | 7 | idence 6 Oth | | |
| Division | tal or Atte | Certification: | 3 Suicide 6 Could not determined | | home, ferm, str cify) | reet, fectory, office | в | | (Street and Numb wn, State) | er or Rural Route I | Vumber, |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi | edicai | 29e. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medical Exa | hysician: To the best of my ki miner: On the basis of exami end menner steted. | nowledge, deeth netion end/or in | n occurred at the vestigation, in my | time, dete end plec opinion, deeth occ | e, end due to the urred et the time, | ceuse(s) end ma dete end place, | nner as stated. and due to the ceu | se(s) |
| | Tot Total | Σ | 29b. Signeture and title of certifier Resture | Wigh | + | 29c. Licer | se number | 40 | 0 11 | (Month, Day, Yea | 00 |
| | No. | | 30. Name and address of person who Frestine W | right FAIR | HOVEN | 11 541 | KESVIL | LE | ND 21 | 784 | |
| | Sta Registr | | 31. Fall (Month Day Year) | Sen 32 Begistrer's St | nature Apo | also | | | | | |



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State of Maryland / Department of Health and Mental Hygiene

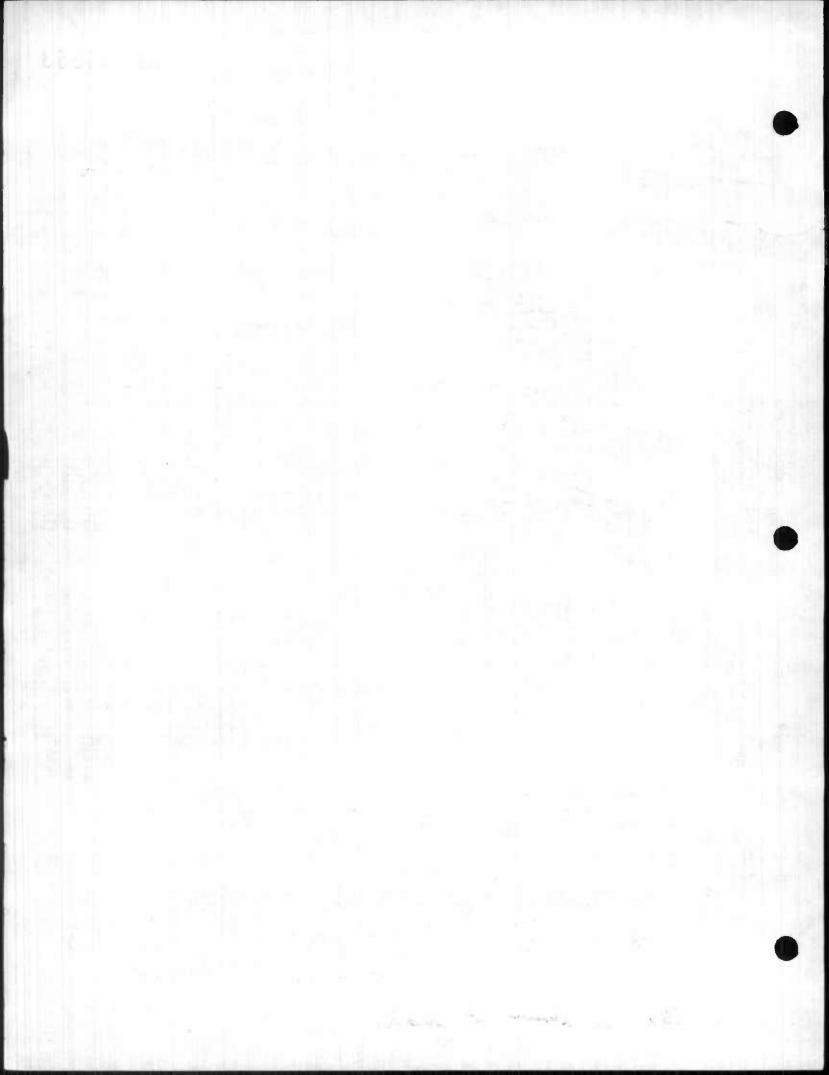
Certificate of Death

Control Death

Control Death

Control Death

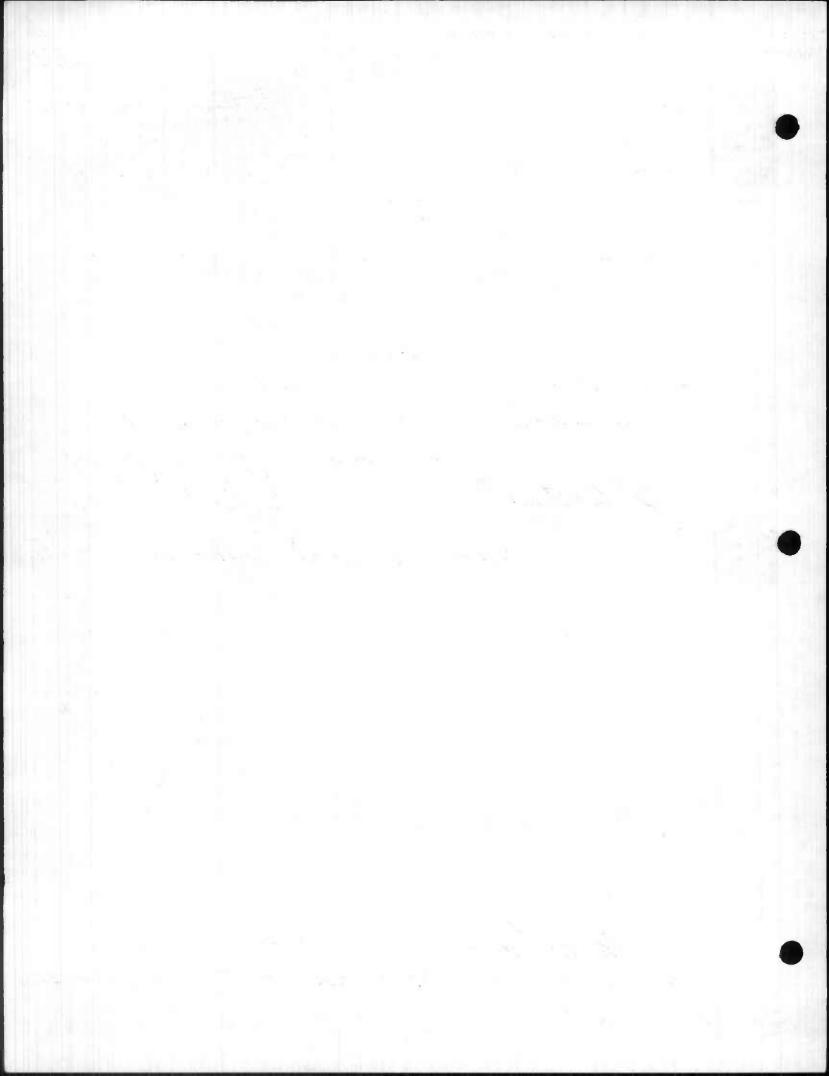
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|------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|---------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------|
| Physician | _ | ecedent's Name (First, Middle, Las | | | Sn. | | | 2. Date of De Month | eath Day | Year | 3. Time of Death |
| /Medical | | Cerula 1. | Anthum | 1 ' | 377. | | | 1-0 | - | 2000 | 1300 |
| Examiner | | Facility Nama (If not institution, give | | | | | | r Location of Deat | , | | |
| | | OWARD COUNTY GEN | | 4 | at a st Million | der 1 Year | COLUMBIA If Under 24 H | | HOW | | |
| uneral irector | | | ex 7. Age | (In yrs. last b | Yrs. Mont | | Hours Mi | | | Country | ce (State or Fore y) ISYLVANI |
| 1 | | al Residence of Decedent Stela 10b. County | | 10c. City. Toy | vn or Location | | | | | 100 | f. Inside City Lim |
| adail of | | | | , , , , , , , , , , , , , , , , , , , | | | | | | 1.00 | 1 ☐ Yas 2() |
| or 28a-f s be notified Directo | 100 | ARYLAND ANNE Street and Number | ARUNDEL | | SEVE | Zip Code | | | 10g. Citizen of V | Mat Causta | |
| | | 914 FOXHOUND COU | RT | | Tol. | | 21144 | | U.: | S.A. | |
| at', or lame 23. Examiner must by Funeral | | Marrital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates: | | If Yes, a | cedent of h specify Cub | an, Mexican, Pu | (Specify Yes or No orto Rican, etc.) | Blac | e - Americar k, White, et WHITE | C. |
| or the Medical Completed | | 15. Decedent's Ed | lucation | 168 | Decedent's U | Isual Occup | pation | mekina | 16b. Kind of Bu | usiness/Indu | stry |
| had old | E | (Specify only highest gra lementery/Secondary (0-12) | College (1-4or 5- | r) | life. DO NO | T use retire | during most of w | orking | | | |
| H H | | 12 | | | ECURITY | GUAR | D | | DISTI | LLERY | |
| a other | 17. | Father's Name (First, Middle, Last) | | | | | 18. Mother's N | ame (First, Middle | , Maiden Sumam | (0) | |
| To To | H | ERBERT | T. | ANTH | ONY | | MARGARI | ET S. | G | ARBER | |
| E 5 | 198 | . Informant's Name/Relationship (| Type, Print) | 19 | b. Meiling Addr | ess (Street | and Number or | Rural Route Numb | er, City or Town, | State, Zip C | iode) |
| 27 | E | VELYN E. ANTHONY | (WIFE) | 1 | 914 FOX | HOUND | COURT, | SEVERN, | MD. 2114 | 44 | |
| # # H | 20a | Method of Disposition | | 20b. Place | of Disposition (| Name of | | Date | 20c. Location - | | n, State |
| 10 0 | | 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | | | | | | 12/22/200 | | 77777 | MD |
| ortant: Injury | 21. | Signature of Funeral Societ Licen | | MARIL | | | S CEMETER | | CROWNS | | |
| M M | " | | | | | | | INGLETON | | | |
| | | a. Part1. Enter the diseasa, or comp shock or heart failure. List only | lea | | | | | S.W., GLE | | | 21061 Approximate Interval Between |
| aminer 💆 | res | ease or condition ulting in death) | | oue to (or as a | consequence | of): | | | | | |
| n and iel-transit Examiner | Sar | upotially list conditions | D | | consequence | of): | | | | | |
| | | quentially list conditions, ny, leeding to immediate se. Enter Underlying use (Disease or Injury initiated events | c | | | | | | | | |
| 0 4 5 | | ulting In death) Last | d | Oue to (or es a | consequence | of): | | | | | |
| d by the attendir setached for use Physician/A | | | | | | | | | 6 | | |
| ysi ys | Part | II. Other algnificant conditions of | | t not resulting | in the underlyir | ng cause gi | ven in Part f. | 23b. Did | tobacco use co | ntribute to t | he cause of de |
| signed by the attendit d be detached for use d by Physician/I | | mitastate lun | 3 canan | | | | | هر | Yes 2□No | 3 Probe | bly 4 ☐ Unk |
| shoul ete | _ | | | | | | | | s an autopsy ormed? | avail | e autopsy findin lable prior to pletion of cause eath? |
| has pe 2 | | | | | | | | 10 | Yas 2010 | 10 | Yes 2□ No |
| 0 8 0 | | Was case referred to medical | | | | | OC Diseased D | | | | 100 20110 |
| or, page | | | Manadal. | • • 🗆 = 0.00 | | DOA ON | her | eath (Check only | | (04.1 | |
| rector rector | 25. | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | N 2LIEMO | utpatient 3 | DON | 4 LI NUISING | Home 5 Res | | | |
| s certific director | 25. | | 1 Impatier | | Time of | 28c. Inju | rv at | 28d. Describe | LIGA ILHOLA OCCUL | | |
| After this certific funeral director tion: To Be | 25. | 1 ☐ Yes 2☐ No Manner of Death 1 ☐ Netural 5 ☐ Pending | 28a. Date of Injun (Month, Day | | Time of fnjury | 28c. Inju Wo | | 28d. Describe | now injury occur | .00 | |
| After this certific funeral director tion: To Be | 25. | 1 ☐ Yes 2€ No Manner of Death | 28a. Date of Injun (Month, Day | Year) 28b. | | 10 | ny at wk?]Yes 2∐No | 28f. Location (| (Street and Numb | | Route Number, |
| After this certific funeral director tion: To Be | 25. | Manner of Death Netural 5 Pending Accident 3 Suicide Homicide Certifying Ph. (Check only 2 Medical Exam | 28a. Date of Injun (Month, Day) 28e. Place of Injun building, etc. yelclan: To the best of | Year) 28b. ry - At home, f (Specify) my knowledgexaminetion as | erm, street, fac | 1 ctory, office | Yes 2 No | 28f. Location (City or To | (Street and Numb wn, State) | er or Rural i | ted. |
| After this certific funeral director tion: To Be | 25. 27. | Manner of Death Netural Netural Noticide Solution Noticide Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solutio | 28a. Date of Injun (Month, Day) 28a. Place of Injun building, etc. | Year) 28b. ry - At home, f (Specify) my knowledgexaminetion as | erm, street, fac e, death occur ad/or investigat | tory, office | Yes 2 No | 28f. Location (City or To | (Street and Numb wn, State) cause(s) and ma date and place, | er or Rural i | ted. he cause(s) |
| at Director: After this certification by the funeral director Certification: To Be | 25. 27. | Manner of Death Netural 5 Pending Accident 3 Suicide Homicide Certifying Ph. (Check only 2 Medical Exam | 28a. Date of Injun (Month, Day) 28e. Place of fnjun building, etc. yetclan: To the best of and manner stel | Year) 28b. ry - At home, f (Specify) if my knowledgexaminetion ared. | e, death occur end/or investigat | attory, office | me, date and pla opinion, death oc | 28f. Location (City or To | (Street and Numb www., State) cause(s) and ma date and place, 29d. Data signe | ner or Rural i | ted. he cause(s) |
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| After this certific funeral director tion: To Be | 25. 27. 29a | Manner of Death Netural Netural Noticide Solution Noticide Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solutio | 28a. Date of Injun (Month, Day) 28e. Place of fnjun building, etc. yetclan: To the best of and manner stel | Year) 28b. ry - At home, f (Specify) if my knowledgexaminetion ared. | e, death occur end/or investigat | attory, office | me, date and pla opinion, death oc | 28f. Location (City or To | (Street and Numb www., State) cause(s) and ma date and place, 29d. Data signe | ner or Rural i | ted. he cause(s) sy, Year) |



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| | | | | State of Mi | arylana / | | ificate of | | | Reg. No. | J | 15356 |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------|-----------------------|-------------------------------------------------------|---------------------------------------------------------|-----------------------------------------|-------------------------------|---------------------------|-------------------------------------------------------------------------|
| | Physici | an | Decedant's Nama (First, Middla, La: Helen Frances Block | | | | | | 2. Data of De Month | Day | Year | 3. Tima of Deeth |
| | /Media | al | | | | | | th City Town or I | Februa | 4 | | 3:00 AM |
| 7 | Examir | er | 4a. Fecility Neme (If not institution, given Manor Care - Ruxto | | | | | 4b. City, Town, or L Towson | ocation of Death | | imor | e |
| | Funeral Director | | 217 07 0047 | ax 7. Ag ☐ M 2/XXF | a (In yrs. last | | If Undar 1 Yeer Months Days | If Under 24 Hrs. Hours Min. | 8. Data of Bir (Month, Da Feb. 12 | y. Year) 1, 1912 | 9. Birthp Coun Mary | elaca (State or Foreign etry) yland |
| | and w | | Usual Rasidanca of Decedent 10a. Stete 10b. County | | 10c. City, To | wn or Loca | ition | | | | 1 | 0d. Inside City Limits |
| | death with the Maryland ms 23s or 28s-f show prust be nothed at | tor | Maryland Baltimon | ce | Towso | | | | | | | 1 ☐ Yas 2 💢 No |
| | or 28s | lrec | 10e. Street end Number | | 1 | | 10f. Zip Coda | | | 10g. Citizan of W | /hat Coun | itry? |
| | 23a c | ai | 23 Acorn Cir. | | | | 21286 | | | United | Stat | es |
| 020 | or its | by Funeral Director | 11. Meritel Stetus 1 X Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedant Armed Forcas? 1 ☐ Yas 2 ☒ I If Yas, Giva Yaer or Datas: | Evar in U,S. No | | as Decedent of H (as, specify Cubin DYas 2 X No | tispenic Origin? (Sp an, Maxican, Puarto Specify: | ecify Yas or No Rican, etc.) | - 14. Race Blac Specify | k, White, | en Indien, etc. lite |
| Maryland 21215-0020 | flied within 72 hours Hygiene "naturel", ther then "naturel", ent, tre Medical Ent | Completed | 15. Decedent's Ec (Spacify only highast gra Elemantery/Secondery (0-12) | lucation da complated) Collega (1-4or 5 | 5+) | (Give kir lifa. DC | | petion during most of work d) | ing | 16b. Kind of Bu | | Justry |
| 2 | hygier ther th | ပိ | 12 17. Fether's Nama (First, Middla, Last) | | b | ookke | eper | 40 Mothada Nam | o (Final Adiabata | bankir | | |
| and | 2 should be filed and Mental Hygi Is marked other raumatic event, I | o Be | Frederick H. Block | | | | | 18. Mothar's Nam | ta W. R | | a <i>)</i> | |
| ary | should be and Mental marked or umatic eve | 7 | 19a. Informant's Name/Ratationship (| Type, Print) | 1: | 9b. Mailing | Addrass (Streat | and Number or Rui | | | Stata, Zip | Code) |
| | and 2 alth a 127 is er tra | | Elizabeth Yenni/s | ister | | 816 | Mockingl | oird Lane | Tows | on, MD | 2128 | 6 |
| Baltimore, | permit. Pages 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other eny injury or other traumatic event, 9059. | | 20a. Method of Disposition 1 X Burlal 2 Cremetion 3 4 Donation 5 Other (Specify | | | | tion (Nama of tory or other place Cemetery | | Data /25/00 | 20c. Location - | | own, Stata Maryland |
| Balt | permit. Departr Importa eny inje | | 21. Signeture of Funaral Sarvice Licen | thill IV | - | 22. 1 | Nama and Addra | 650 | 0 York | Rd. | | eral Home, In |
| | _ | | 23a Fart1. Enter the disease, or compensor, or heart failure. List only | olications that causad | tha daath. D | o not enter | tha moda of dyir | ng, such as cardiac | or raspiratory a | Marylar rest, | IQ Z | 1212 Approximete Intervet Between |
| | Physician /Medicai Examiner | | Immediata Causa (Final disaase or condition rasulting in deeth) | · Acu | | | | 1 | - 0 | | | Minutes. |
| | | - | resouring in deetily | | Dua to (or es | a gonseque | ance of): | | | | | |
| 0, | icate be executed physician and s the burial-transit | Examiner | Sequantialty list conditions, if any, laading to Immadiata cause. Entar Undarlying Causa (Disaasa or Injury that Initiated events | b | Dua to (or as | a consequa | anca of): | | | | | |
| x 68760, | 25 00 0 | Medicai | Causa (Disaasa or Injury that Initiated events rasulting In death) Lest | d | Dua to (or as | a consequa | inca of): | | | | | |
| Вох | death cert e ettendin ed for use | Physician/M | | 0. | | | | | | | | |
| P.O. | y the deche | nysic | Part II. Other significant conditions of | ontributing to death be | ut not rasulting | in tha und | arlying causa giv | an in Part I. | | | | the cause of death? |
| | ires that the death cert signed by the ettendin d be deteched for use | by Pi | | | | | | | 1 | Yes 2□ No | 3 Prot | bably 45 Unknown |
| Records, | reen | Completed t | | | | | | | 24a. Was perfo | an autopsy med? | COI | ere autopsy findings ailabla prior to mplation of cause death? |
| E. | The i | Com | | | | | | | 10 | Yas 20 No | 1 🗆 | Yas 2 No |
| Vital | sician: The law certificete hes b director, page 2 s | Be | 25. Was casa rafarred to medical axaminar? | A la auditali | | | 0.11 | 26. Place of Deet | | | | |
| of | Physician: or this certific eral director, | n: To | 1 ☐ Yas 2 No 27. Mannar of Death | Hospital: 1 ☐ Inpatia 28a. Date of Injur | ry 28b | . Ttma of | 3□ DOA Oth | 4 Lighursing Ho | | danca 6 Othe | | ν) |
| io | Attanding or death. ector: After by the fune | ation | 1 Abaturat 5 ☐ Panding 2 ☐ Accident invastigation | (Month, Day | y Year) | Injury | | k? Yas 2□No | | | | |
| Division | el or Attanding P s efter death. I Director: After t d in by the funers | Certification: | 3 Sulcida 6 Could not be determined | 28a. Placa of Injubuilding, ato | ury - At homa, c. (Specify) | farm, straa | t, factory, offica | | 28f. Location (: City or Tou | Street and Numb vn, State) | er or Rura | I Routa Number, |
| | To the Hospital or Attanding Physician: within 24 hours after death. To the Funerel Director After this certific completely filled in by the funeral director. | edical | 29a. Certifier (Check only one) 1 Certifying Physics 2 Medical Example 1 | valcian: To the best of linar: On the basis of and mannar sta | axamination a | and/or thvas | stigation, in my o | pinton, daath occur | red at tha time, | data and place, a | and dua to | tha cause(s) |
| | To the to the composition of the total | Σ | 29b. Signatura and title of cartifiar | 2/1 | | | 29c. Licans | a number | | 29d. Dete signed | (Month, | Day, Year) |
| | | | Ma | ladin. | 2 | | 0- | 1684 | 9 | x-2 | 1-0 | 0 |
| _ | Q | | 30. Nama and addrass of person who of | completed causa of de | aath (Itam 23a | (Type, Pr | 100 OSL | ER DI | . 700 | USON | Ma | Dey, Year) 20 4. 21204 |
| 2 | Sta Registr | | 31. Date filed (Month, Day, Year) FFR 2 2 2 | | ar's Signeture | 6. | Spark | 2 | | | | |

DHMH 16 Rev 6/95



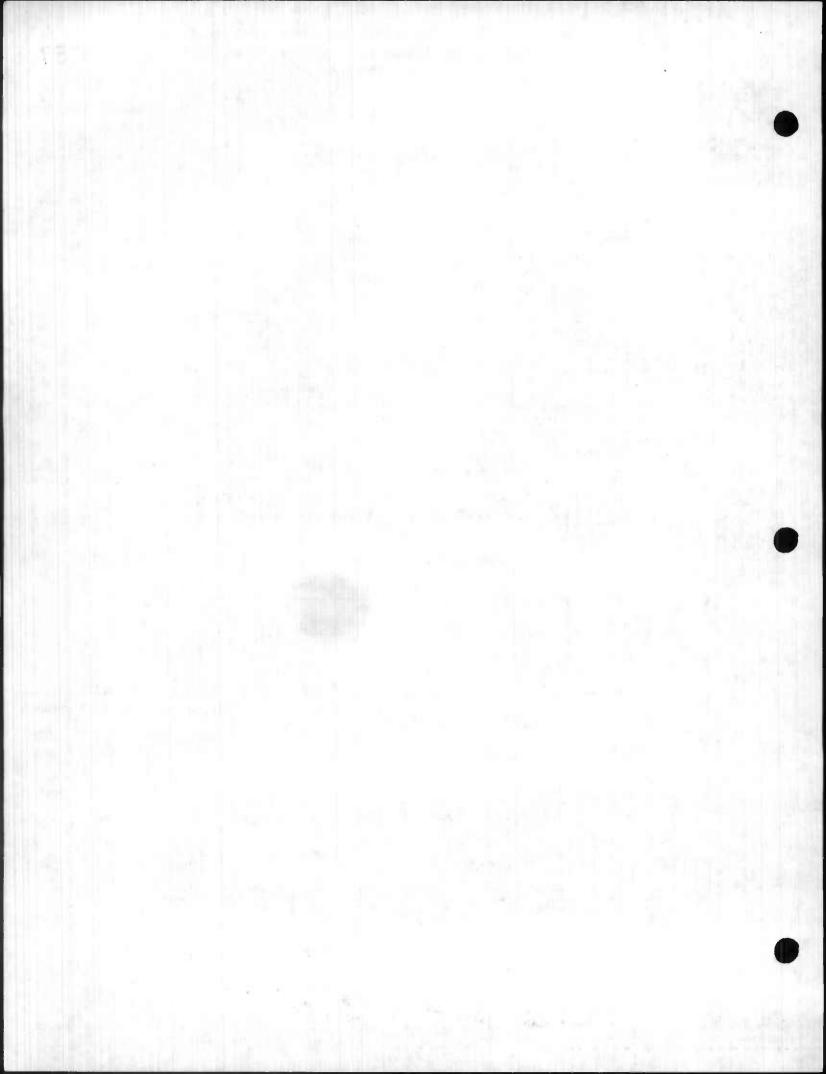
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05357 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Yaai **Physician** Ethel M. BAILEY 10 2000 13:04 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Trunder 24 firs. 8. Date of Birth (Month, Day, Year) SINAI HOSPITAL 5. Social Security Number If Undar 1 Yeer 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 20 F 225-14-3647 Yrs 81 07-6-18 Director VIRGINIA Usual Rasidence of Decedant 10a Stata 10b. Count 10c. City. Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1₽ Yes 2□ No MD. PALTIMORE Director 10a. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 5231 CUTHBERT AVE. Funeral 21215 14. Race · American Indian, 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Maxicen, Puerto Rican, atc.) Bleck, Whita, atc. 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: 1 ☐ Never Married 2 ☐ Merried Maryland 21215-0020 1 Yas 2X No Specify: Specify: BLACK ģ 3℃ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) COOK 6 GRADE 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maiden Sumema) 2 should be t and Mental I JOHN DIXON GRACE DIXON 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) important of Health an important: If New 27 is n any injury or other 1 MARY OWENS DAUGHTER 5231 CUTHBERT AVE. BALTO. MD. Saltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata DBurial 2 ☐ Cremation 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Othar (Specify) ZION CEMETERY 02 - 19B ALTIMORE 22. Nama and Addrass of Fecility WILLIAM C. BROWN COMM. F.H. P.A. 21. Signature of Funarel Survice U Desource 1206 W. North Ave. Balto. Md. 23e. Party. Elver the disaasa, or complications that ceused tha daeth. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast, shock, or haart feilura. List only ona causa on aech lina. Approximata Intarval Batween Onsat and Death Physician /Medical Immediata Cause (Finat disease or condition rasulting in death) months Small cell lung cancer Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Sequantiatly list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Diseasa or Injury Dua to (or as a consequence of): the attending physician and Box 68760, thet initiated events rasulting in death) Last Dua to (or as a consequence of): been signed by the a should be detached Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 X Probably 4 ☐ Unknown Peripheral artery disease Division of Vital Records, by Hypertension Hypercholesterolemia 24e. Wes an autopsy performed? 24b. Wara autopsy findings Completed available prior to completion of cause of death? page 2 s Cerebro vascular Accident 1 Vas 2 No 1 Yas 2 No Seizure this certificate 25. Was cesa refarred to medicel axaminar? I or Attending Physician: after death. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only ona) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred 5 Panding Invastigation 1 Naturat Iniun 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 125 Certifying Phyelcian: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, end due to the ceuse(s) 29a. Certifiar and mannar stated. 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Signatura and titla of certifiar Feb-15, 2000 Robert Tao-Ping Chas D 34851 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Belvedere Ave Baltimore, MD 21215 2435 31. Date filed (Month, Dey, Year) 32. Register's Signatura State Deversa

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Biack Indelibie Ink. Assure Ail Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 05358 Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death DORUTH Dey nown **Physician** 4813 200 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia, MD Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

No. 1 Yes Months Days Hours Min. 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 181-10-8339 1 □ M 2KW 86 Yrs. Director PA Usual Residence of Decedent the Maryland notified at 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Columbia Maryland Howard 1 Yas 200 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? must be r 6334 Cedar Lane 21044 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. al Hygiene.
I other than "natural", or themsevent, the Medical Examiner or 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status filed within 72 hours after 1 Yes 202 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 25tNo Specify: White Specify: þ 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 0 Checker Dental Supply Company 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit iment of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even Be Matilda Hehn Warwick Freeman 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Debbie Young / Daughter 578 Sunshine Way, Westminster Maryland 21157 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cemetary, crematory or other plece) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from Stete Department of Important: If any injury or Cape May County Crematory Feb. 23, 2000 Lower Township, NJ 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name end Address of Facility Charles L. Stevens Funeral Home, Inc. 21230 1501 East Fort Avenue, Baltimore Maryland 23a. Pert1. Enter the diseese, or complications that caused the shock, or heart feilura. List only one cause on each lina. death. Do not entar the moda of dying, such as cardiac or raspiratory arrast, Approximata Intervel Between Onset and Deeth Physician /Medical Immediate Causa (Final ACUR? Myscarmi disease or condition resulting in deeth) Examiner Physician/Medical Examiner Huml hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Peremus Due to (or as a consequence of) 60 hibrelletin Money 980 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Onknown signed t þ 24b. Wara eutopsy findings available prior to 24e. Was an autopsy performed? should Completed completion of cause of death? page 2 1 Yes 2 No 1 Yas No certificate Physician: 25. Was casa referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Menner of Deeth 28b. Tima of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Affer 5 Pending investigation Division or Attending 1 Maturel 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 2 4 ☐ Homicide filled in Hospital **Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

**Di Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -34868

State Registrar PARrows

PIL

Clubras, uno

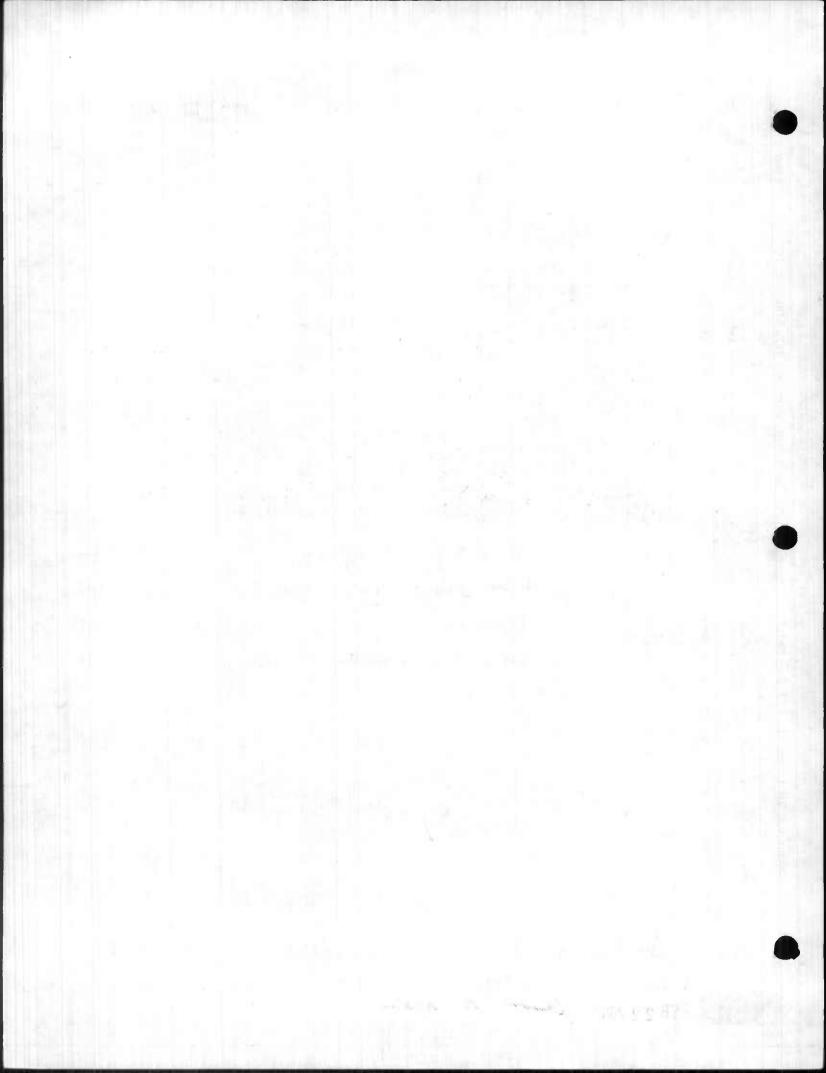
30. Name end eddrass of person who completed cause of death (Item 23a) (Type, Print)

11000

FEB 2 2 2000

LITTUR

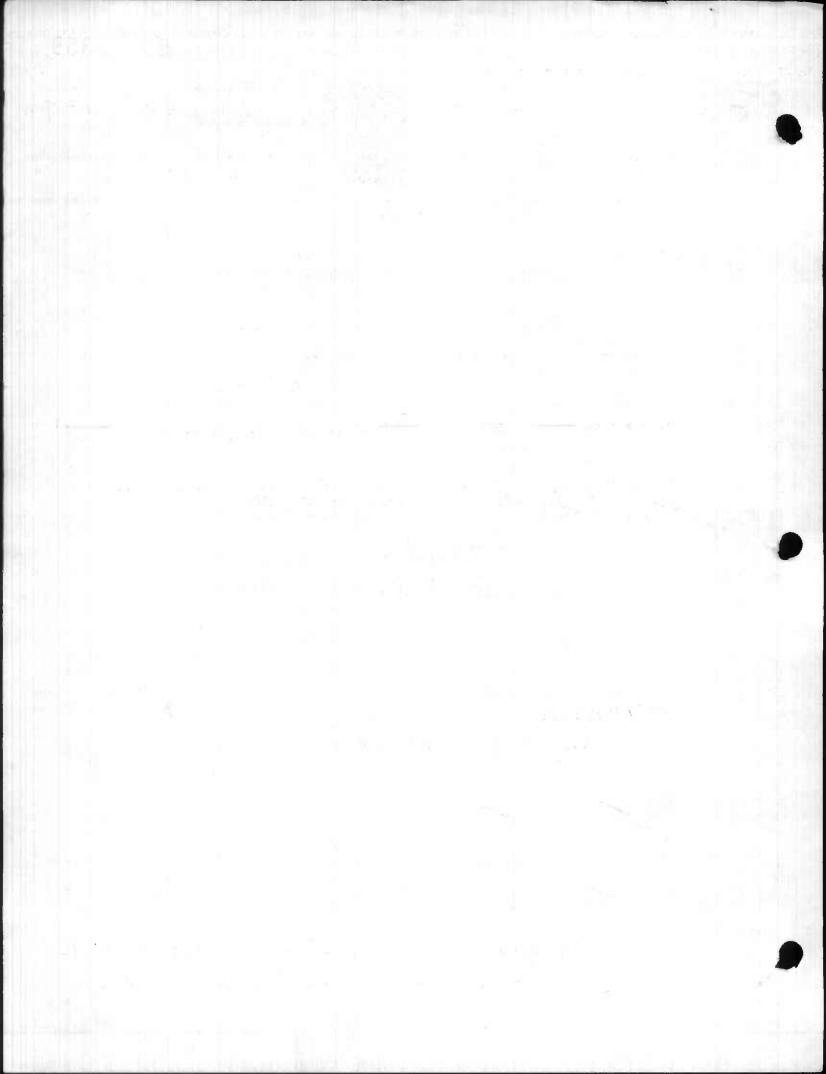
32. Registrare Signature



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State of Maryland / Department of Health and Mental Hygiene 0 0 5 3 5 9

| | | | AMEND#19A&B PER INF | | - | - | | neaith and M Death | | eg. No. | | ,005 |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------|----------------------------------------|----------------------------------|------------------------------------------------------------|--------------------------------------------|-------------------------------------|-----------------------------|----------------------------------------------------------------------|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, | | ter | | | | 2. Date of Dee Month February | Day | Year | 3. Time of Death |
| | Exami | | 4a. Facility Name (If not institution, BON SECOURS HOS | restriction in the | r) | | 4 | 4b. City, Town, or Lo BALTIMO | cation of Death | 4c. County | of Deeth N/A | |
| l | Funeral Director | P | 5. Social Security Number 161–14–7968 | | age (In yrs. last birt | hday) If Under Months | 1 Year Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day Feb 27, | Year) 1913 | | ace (Stete or Foreign ry) A |
| | wo wa | | Usual Residence of Decadent 10a. State 10b. County | | 10c. City, Town | or Location | | | | | 10 | d. Inside City Limits |
| | Mary | ctor | MD N/A | | В | altimore | | | | | | 1 Yes 2 □ No |
| | 10 P V V V V V V V V V V V V V V V V V V | Direc | 10e. Street and Number | | | 10f. Zip | Code | | 1 | 0g. Citizen of W | hat Count | ry? |
| | e 23e | erai | 3300 Alto Rd | 10 Mac Dacades | A Francis III C | 40 W Dd | 11 | 21216 | | | JSA | a la dia |
| 020 | ours effer death with the Manyler els, or ferme 23a or 28a-f show Exeminer must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorcad | 12. Was Deceden Armed Forces d 1 Tyes 2X If Yes, Give Yeer or Dates | ?] No | 13. Was Decede If Yes, speci | | lispanic Origin? (Spe an, Mexican, Puerto I Specify: | Rican, etc.) | | | tc. |
| 21215-0020 | ges 1 end 2 should be filed within 72 hours effer death with the Marylend it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Completed | 15. Decedent's (Specify only highest Elementery/Secondary (0-12) unknown | Education grade completed) College (1-4or | 5+) | | l Occup k done d e retired | during most of workii d} | ing | 16b. Kind of Bu | | |
| DQ 5 | illed Hygi other | Be Co | 17. Father's Name (First, Middle, L. | | IOWII | u | IIIKII | 18. Mother's Name | (First, Middle, | Meiden Sumem | | JWII |
| Maryland | Menta Menta arked artic ev | To B | Clem Dowdy | | | | | Viola 1 | Moses | | | |
| Mar | 12 sho h and is m reum | | 19a. Informant's Neme/Relationshi | | 19b. | Mailing Address | (Street | and Number or Rura | I Route Number | r, City or Town, | State, Zip (| Code) |
| Baltimore, I | permit. Peges 1 end 2 Department of Health a Important: If Item 27 is any injury or other tra ance. | | Viola Alston/-£- 20a. Method of Disposition 1 □ Burial 2 □ Cremation : 4 ☒ Donation 5 □ Other (Spe | B □Removai from State | 20b. Place of | Disposition (Nam v, crematory or of | e 67 | d Mill Roo | d Balt | imore, 20c. Location - | MD City or Tow | 21207 ² 1244 m, State |
| Balti | permit. Departminents any inju | a to the distribution 5 □ Other (Specify) | | | 1 | State A | | ss of Facility Comy Board MD 2120 | | Baltim | ore S | treet |
| | Physician /Medical Examiner | | 23a. Part 1. Enter the disease, or of shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) | omplications that cause only one cause on each | ed the death. Do n | ot enter the mode | of dyin | ig, such as cardiac o | r respiretory arr | est, | | Approximate Interval Between Onset and Death |
| Box 68760, | eath certificets be axecuted ettanding physician and for use es the bunal-transit | an/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last | b [N]{6 | Due to (or es e c | | bita | is Ul | Cer | | | |
| .O. E | thet the death cert ed by the ettendin detached for use | Physician/M | Part II. Other significant condition | s contributing to death | but not resulting in | the underlying ca | use giv | en in Part I. | 23b. Did to | obacco usa con | tribute to | the cause of death? |
| Q | thet the | | clementi | A | | | | | 1 🗆 Y | • 2 No | 3 Prob | ably 4 Unknown |
| of Vital Records, | v requiras been sign should be | Completed by | Coronar | 1 Arte | ery o | liser | くて | | 24a. Was a perfor | | com | re autopsy findings llable prior to apletion of cause eeth? |
| al R | The ata h | Соп | | | | | | | 1 🗆 Y | es 2□No | 10 | Yes 2□ No |
| Vita | Physician: this certific | o Be | 25. Wes case referred to medical examiner? 1 Yes 2 P No | Hospitel: | | | Oth | 26. Place of Deeth | | | | |
| | or Attending Physical death. Director: Affar this in by the funeral di | ation: To | 27. Menner of Beath 1 Matural 5 Pending 2 Accident Investiga | | ury 28b. T | | Bc. Injun Wor | 4 LI Nursing Hor | | ence 6 LIOthe | | |
| Division | | Certification: | 3 Suicide 6 Could no determin | ed 286. Placa of Ir building, e | njury - At home, far vtc. <i>(Specify)</i> | | | | City or Tow | | | |
| | to the Hospital | Medicai | 29a. Certifier 1 Certifying (Check only one) 2 Madical E | Physician: To the best taminar: On the basis of and manner s | of examination and | death occurred a /or investigation, | it the tin | ne, dete end placa, a pinion, death occurre | and due to the c ed at the time, d | ause(s) and mai ate and placa, a | nner es sta ind due to t | ited. the causa(s) |
| | to the Ho Within 24 To the Fu | M | 29b. Signature and title of cartifier | and manner s | nutou. | 29c. | Licens | e number | 2 | 9d. Date signed | (Month, D | lay, Year) |
| 1 | 1 | | ► CDKeA | mey my | | | D7 | 27860 | | Februa | MylC | 1,2000 |
| ^ | 4 | | 30. Name and address of person w | no completed cause of R D , KEA | RNEYN | Type, Print) | D,WI | ASH. BIVE | O. BAZ | T.MD | 212 | 230 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 2. 2 | 32. Regist | trar's Signature | 13 14 | 1000 | al al | | | | |



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State of Maryland / Department of Health and Mental Hygien 0 5 3 6 0

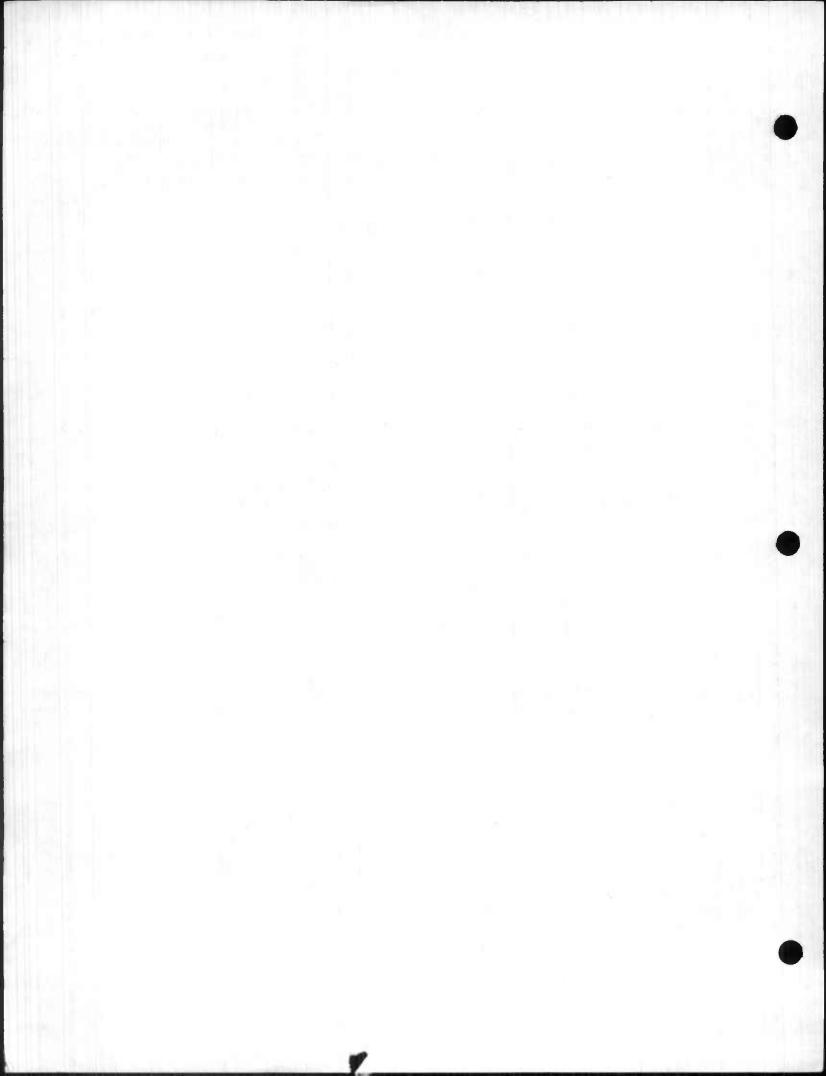
Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Veer **Physician** ADELAIDE BURCHARD LEATHA 5-12 AM FEBRUARY 11, 2000 /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAMSPORT RETIREMENT VILLAGE WILLIAMSPORT WASHINGTON 7. Age (In yrs. lest birthday) If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex Birthplece (Steta or Foreign Country) **Funeral** 1□M 2\ F 192-24-5123 Yrs. Director 93 Aug 1, 1906 USA Usuei Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified as 1 1 Yas 2 □ No Director Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? 154 N. Artizan St 21795 death USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Biack, White, etc. permit. Peges 1 end 2 should be filed within 72 hours efter d Department of Health and Mental hygiene. Important: if Item 27 is marked other than "patural" or Iten any Injury or other traumatic event, the Medical Examina-1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Datas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 € Widowad 4 Divorced white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Eiementery/Secondary (0-12) Coilege (1-4or 5+) 12 unknown teacher education
18. Mother's Neme (First, Middle, Meiden Surmeme) 17. Fether's Neme (First, Middle, Last) William I. Swift Adlaide Emick 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Williamsport Nursing & Rehab Williamsport, MD 21795
Date 20c. Location - City or Town, Stete 154 N. Artizan St 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 4 N Donetion 5 □ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Neme end Address of Fecility Joseph B Van Sant State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Deeth **Physician** /Medical immediate Ceuse (Fine) ASPIRATION PNEUMONIA disease or condition resulting in death) Examiner Due to (or es e consequence of): DYSPHAGIA

Due to (or es e consequence of): MONTHS physician end the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest ADVANCED ALZHEIMER'S DISEASE Division of Vital Records, P.O. Box 68760, Physician/Medical Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 ☐ Probably 4 € Unknown 1 Yes 2 No HEART FAILURE 24b. Ware eutopsy findings available prior to compiation of causa of deeth? 24e. Wes en eutopsy performed? Completed 1 Yas 28 No after distance of the continued of the contract of the contractor. After this certified 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1□ Yes 2No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in to Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

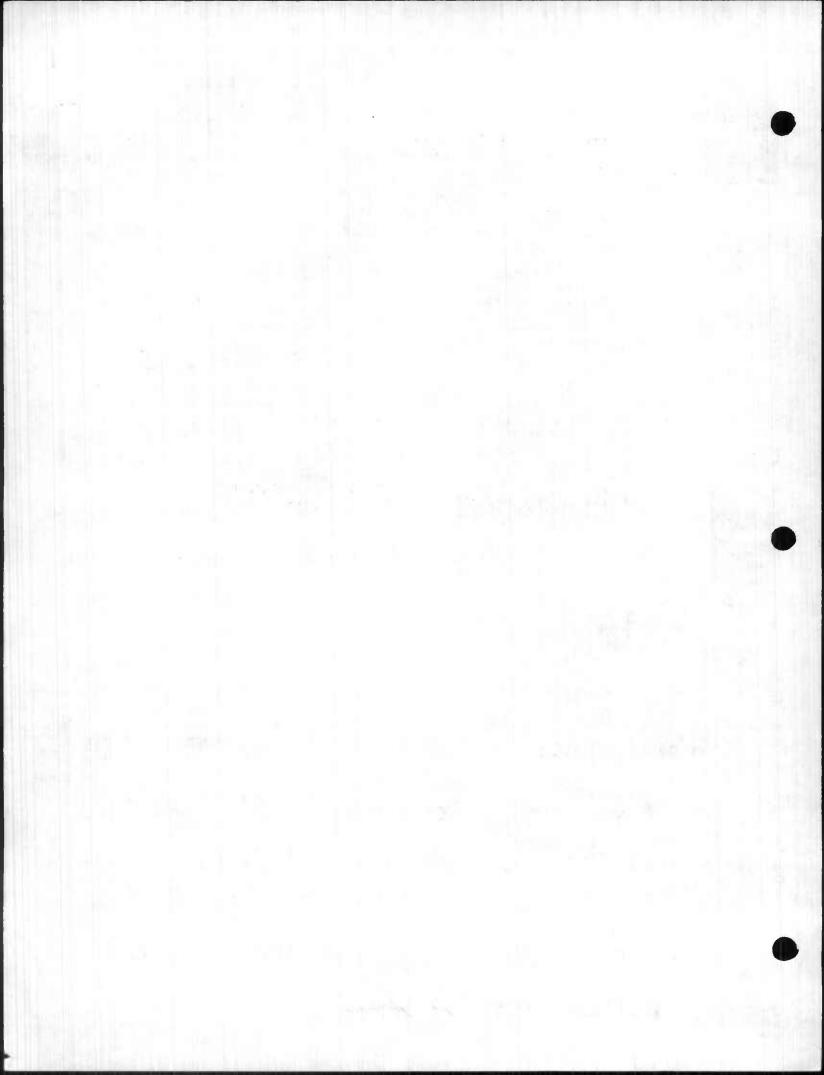
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29e. Certifier Medical 29c. Licanse number 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Yeer) D42046 - STAFF PHYSICIAN 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 31. Dete filed (Month, Dey, Year) 32. Registraris Signeture State FEB22 Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 0 0536 |

| _ | | | | Certifica | ate of | Death | | eg. No. | 0000 | | | |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------|-----------------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------|--|--|
| hysician | Decedent's Name (First, Middle, Last | st) | | | | | 2. Date of Dear Month | Day | Year | of Death | | |
| edical | JANE A. BENSON | n means a contra | | | | | FEB. | 14, 200 | | 07 P.M. | | |
| aminer | 4a Facility Nama (If not institution, give | | | | | mater a sur | Location of Death | 4c. County | | | | |
| | GREATER BALTIMO | | | Milas | ler 1 Year | TOWSON If Under 24 Hrs | | | LTIMORE | | | |
| eral ctor | 5. Social Security Number 6. S 212-10-3448 | 0 M 2 1 F 7. Ag | 82 | Yrs. Month | | | | Year) | Birthplace (State Country) MARYLANI | or Foreign | | |
| e notified at Director | 10a. State 10b. County MD BALTIMO | RE | 10c. City, Town | | | | | | 10d. Inside | City Limits | | |
| Director | 10e. Street and Number | | | 101.2 | ip Code | | 1 | 0g. Citizen of \ | What Country? | | | |
| | 615 CHESTNUT AV | | | | 212 | | | US | | | | |
| by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent I Armed Forces? 1 Yas 2 N I If Yes, Give Year or Dates: | | | ecify Cub | | Specify Yes or No- nto Rican, etc.) | | ck, Whita, etc. | | | |
| eted | 15. Decedent's Ed (Specify only highest gra | ducation de completed) | 16a. | Decedent's Us | ual Occu | pation during most of wo | orkina | 16b. Kind of B | usiness/Industry | | | |
| Completed | Elementary/Secondary (0-12) 12TH GRADE | College (1-4or 5 | | Viite. DO NOT OMEMAKE | | od) | | OWN | HOME | | | |
| Bec | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Na | me (First, Middle, I | Maiden Suman | 10) | | | |
| 0 | CHARLES F. GRAF, | SR. | | | | MARY | BOND | | | | | |
| , - | 19a. Informant's Name/Relationship (| Type, Print) | 19b. | Mailing Addre | ss (Stree | and Number or R | lural Route Number | , City or Town, | State, Zip Code) | | | |
| | MARY JANE AMPULA | DAUGH | TER 5 | 261 PIN | IE BA | RK CT. | COLUMBIA, | MD 2 | 1045 | | | |
| 00.00 | 20a. Mathod of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 | Removal from State | 20b. Place of cemeter | Disposition (A | lame of r other pla | ce) | Data | 20c. Location - | City or Town, Stata | | | |
| | 4 Donatlog 5 Other (Specif) | | DRUID | RIDGE | CEME | TERY | 2/18/2000 | PIKE | SVILLE, MI |) | | |
| ans ans | 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility THE JOHNSON FUNERAL HOME, P.A. | | | | | | | | | | | |
| | I leather N | * page | DAVENT D | BLVD. TOWSON, MD 21286 rdiac or respiratory arrest, Approximate Interval Between Onset and Death | | | | | | | | |
| dical liner | Immediate Cause (Final disease or condition rasulting in death) | b. | Dua to (or as a c | consequence o | <u>Ca</u> | rebore | scular | dise | ese Zyr | A | | |
| ai Examiner | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury | Due to (or as a consequence of): | | | | | | | | | | |
| se as the bunat-transm /Medical Examir | that Initiated events resulting In death) Last | d | Due to (or as a c | onsequence of |); | | | | | | | |
| by Physician/A | | | | | | | | | 1 | | | |
| Physic | Part II. Other algorificant conditions of | | it not resulting in | the underlying |) causa gi | ven in Part I. | 23b. Did to | | ntribute to the caus 3 Probably 4 | Gnknown | | |
| Completed by Physician/ | Steoarthut | 5 | | | | | | performed? av | | ry findings or to of cause | | |
| wo | | | | | | | 1 🗆 Y | 85 2 No | 1 ☐ Yes 2 | □No | | |
| To Be Com | 25. Was casa raferred to medical | | | | | 26. Place of De | eath (Check only or | | | | | |
| 0 | examiner? | Hospital: 1 ☐ Inpatie | nt 2 ER/Ou | tpatient 3 1 | DOA O | her | Home 5 ☐ Reside | | er (Specify) | | | |
| n: T | 27. Manner of Death | 28a. Data of Injur (Month, Day | | ime of | | ry at | _ | THE RESERVE AND ADDRESS OF THE PARTY. | | | | |
| completely filled in by the funeral Medical Certification: 1 | 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined |) | ıry - At home, fa | mjury M rm, street, facto | 10 | Yes 2 No | 28f. Location (S City or Town | Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| pletely filled i | 29a. Certifier (Check only one) (Check only one) | ysician: To the best of sinar: On the basis of and manner sta | examination and | , death occurre | d at the ti | me, dete and plac opinion, death occ | e, and due to the curred at the time, d | ause(s) and malate and place, | anner as stated. and due to the caus | θ(s) | | |
| Mec Mec | 29b. Signature and titla of cartifier | 7 | 100. | 2 | 29c. License number 29d. Date signed (Month, Day, Year) | | | |) | | | |
| , | · Copyle | w | | | | 8987 | | 2/15/ | | | | |
|) | 30. Name and address of person who care SPERLING, | completed cause of de M.D. 50 | aath (Itam 23a) (| Type, Print) H RAVE | EN B | LUP. B | ALTO. 1 | 10 2 | 1239 | | | |
| State | 31. Date filed (Month, Day, Year) | | r's Signatore | Soon | 61 | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 1 per md G782 4/25/00 vState of Maryland / Department of Health and Mental Hygiene 05362 AMEND#10a,12&19B PER F.H. G781 3-16-2000 JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death WALTER ERNEST BOYER Month Year ter 04:35 AM February 2000 4b. City, Town, or Location of Death 4c. County of Death Baltimore Birthplace (State or Foreign Country)

physician and s the burial-transit certificate be executed Box 68760 P.O. peed

Examiner certificate or Attending Physician: this After after death. 24 hours a Hospital To the F

Physician /Medical 4e Fecility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Med. Center

5. Social Security Number | 6. Sex | 7. Age (in yrs. last birthday) | ff Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number **Funeral** Months Days Hours Min. 1MM 2□F Yrs Director 86 220-03-6296 May 8, 1913 10a. State 10b. County 10c. City, Town or Location ahow Md. Baltimore Directo Dundalk 28e-f 10e. Street and Number 10f. Zip Code flams 23a or must be 6906 Broeing Rd. 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritai Status 72 hours after 1V Yes 2300 1 Never Married 2 Married altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 II No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Finisher 17. Father's Name (First, Middle, Last) 88 12 should be ! n and Mental F is marked of permit. Pages 1 and 2 should be Department of Health and Menta Important if Item 27 is marked any injury or other trearmatic ex-Grant Jacob Boyer Nellie Traub 19a. Informant's Neme/Relationship (Type, Print) Verda Boyer 20b. Plece of Disposition (Name of Feb 24 20a. Method of Disposition cemetery, cremetory or other piece) 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signeture of Funeral Service Licensee 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final urosepsis disease or condition resulting in death) Due to (or as a consequence of): pneumoni Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): an/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. prostate metastatic Division of Vital Records. by 24a. Was an autopsy performed? Completed Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 29a. Certifier Medical (Check only one)

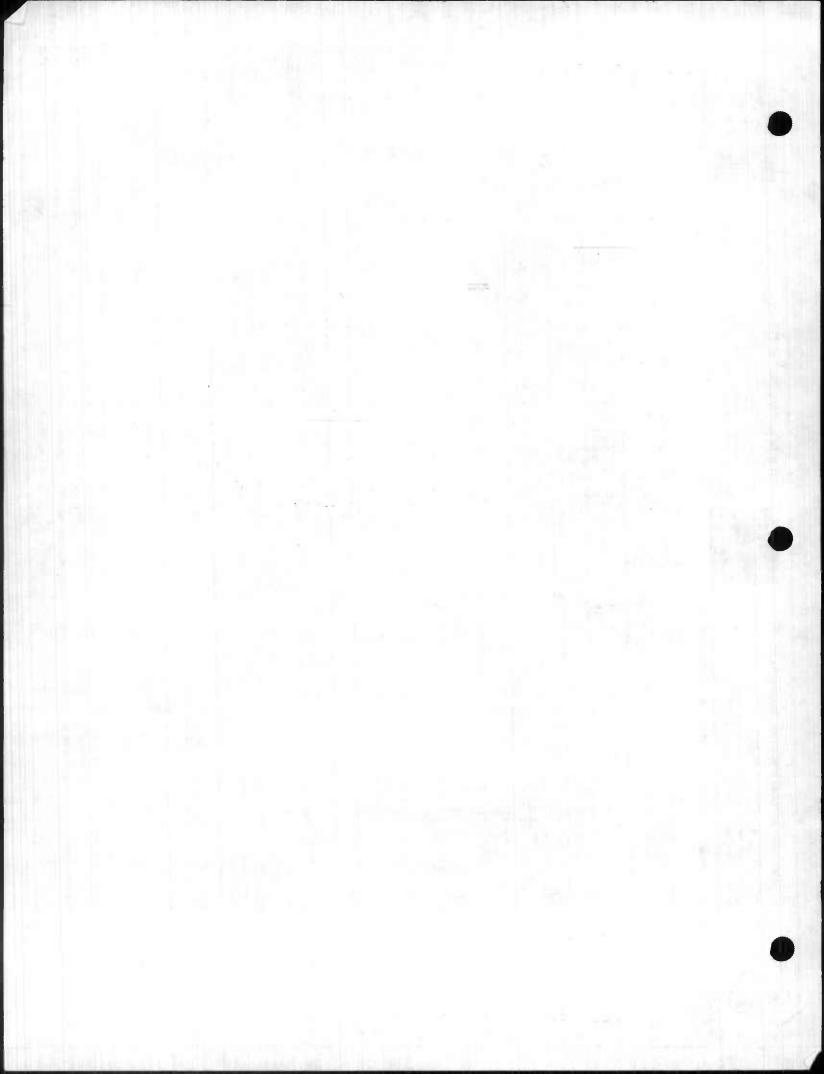
10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Steel 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6906 BROENING Rd. Dundalk, Md. 21222 20c. Location - City or Town, State Dundalk, Md 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 Approximate Interval Between Onset and Death Week Week 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29b. Signeture and title of certifier-29d. Date signed (Month, Day, Year) 29c. License number RES-000 February 21 , 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltimore, Maryland Medical Intensive Care Unit - Bayriew

State Registrar

Matthews Chacko 31. Date filed (Month, Day, Year)

FEB 2 2 2000

32. Registrar's Signature

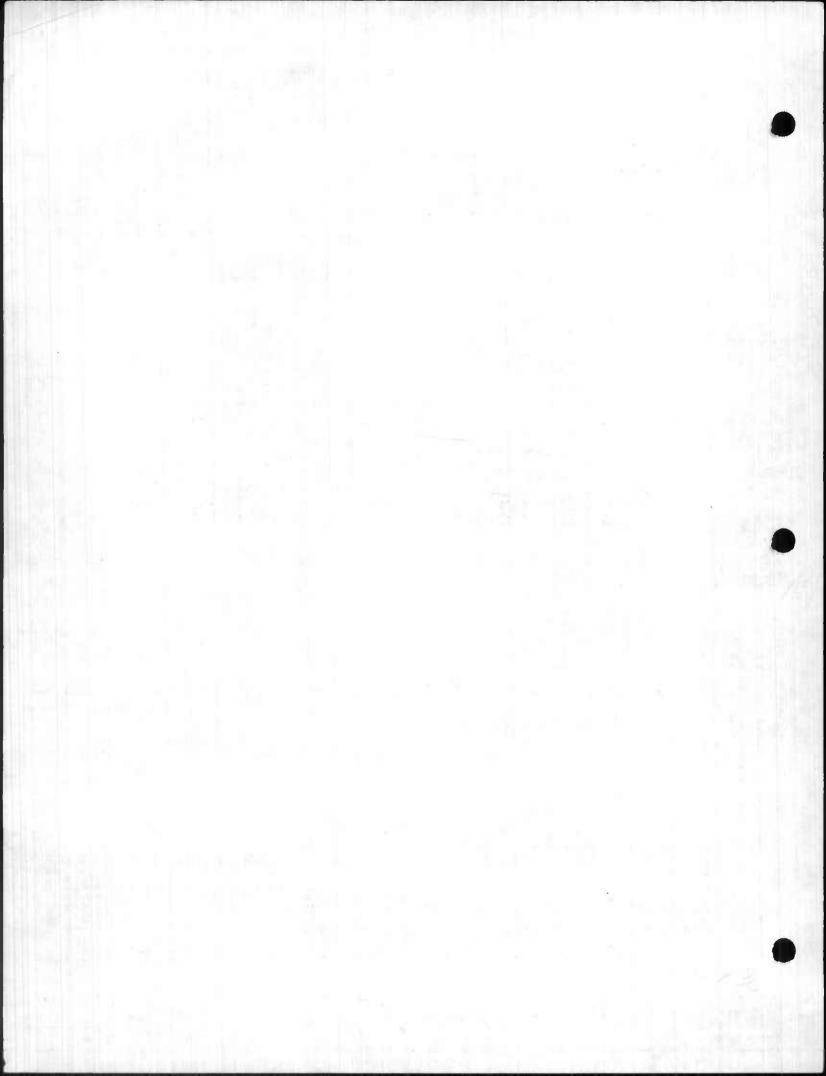


| | Decedent's Name (First, Middle, L. | ast) | | | | 2. Date of De | | 3. Tima of Death | |
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| Physician | Glenwood A. | Beegle | | | | Februa | Day 18/16 5 | Year 2000 10:17 P.N | |
| /Medical Examiner | 4a Facility Nama (If not institution, gi | | | | 4b. City, Town, or I | | | | |
| | FRANKlin SquAR | & HOSPITA | 1/ Ce | nTer | Rosed | 1/0 | BATT | Timore | |
| uneral | 5. Social Security Number 6. | | a (In yrs. last birt | Months Davs | r If Under 24 Hrs. | 8. Date of Bir (Month, De | sy, Year) | Birthplace (State or Foreig Country) | n |
| rector | 205-18-7056 Usual Residence of Decedent | -X | 73 | Yrs. | | April | 26,1926 | Pennsylvania | _ |
| B m | 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limits | |
| 23a or 28a-f ahow unt be notified at rai Director | Maryland Baltimo | ore | Essex | | | | | 1 ☐ Yas 2 ☐ No | |
| x 284 | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of V | Vhat Country? | |
| r tems 23s or 28s-f s observant be notified Funeral Director | 7 Wilbur Road | | | 21221 | | | United | States | |
| Par I | 11. Marital Status | 12. Was Decedent E Armed Forcas? | Evar in U,S. | 13. Wes Decedent of If Yas, specify Cut | Hispanic Origin? (S ban, Mexican, Puert | pecify Yes or No o Rican, etc.) | - 14. Race Biac | e - American Indian, ck, Whita, etc. | |
| ò À | 3 ☐ Widowed 4 ☐ Divorced | | %44 -1 9 | 1□ Yas 2√ No | | , , , , , , , , , , , , , , , , , , , , | Specify | | |
| and and peter | 15. Decedent's E (Specify only highest gr | Education | 16a. | Decedent's Usual Occu | pation | kina | 16b. Kind of Bu | usiness/Industry | |
| | Elementary/Secondary (0-12) | College (1-4or 5- | | (Give kind of work done life. DO NOT use retin | | | | | |
| Co | 12 | | | Assembly Li | Total Control | | | cal Motors | |
| Important: If Itam 27 Is marked other than any Injury or other traumatic avant, that Modes. To Be Comp | 17. Father's Nama (First, Middle, Las Norman Beegle | | | | 18. Mother's Nam | | , Maiden Sumam | 10) | |
| metic. | 19e. Informant's Name/Reletionship | | 105 | Meiling Address (Stree | | | | State Zin Code) | - |
| 27 la r trau | | eegle/ Wife | | Wilbur Roa | | Maryla | | | |
| if itam 2 or other | 20a. Mathod of Disposition | | 20b. Place of | Disposition (Name of y, crematory or other pla | 1 | Date | | City or Town, Stata | |
| T. 0. | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | | | eake Cremat | , | 2/21/00 | Beltsvi | ille, MD | |
| Important: any Injury pncs. | 21. Signature of Funaral Service Lice | ** | | 22. Nama and Addr CAFA Step | | | | 120,120 | |
| any l | Xama C H | ardesty | | RAFA Step | onen D. Lo en Pasture | onrmann | P.A. | ore, MD 21286 | |
| | 23a. Part1. Enlar the disease, or con shock, or heart failure. List only | mplications that caused | tha death. Do n | | | | | Approximate | _ |
| edical | Immediata Causa (Final diseasa or condition | AcuTe | | AR diAl | | o cTia | | Interval Batween Onset and Death | |
| miner el-transit Examiner | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Ather | My o c | consequence of): | IN FA | e cTio | | 24 Hours |) |
| edical Examiner | diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Ather | Dua to (or as a co | consequence of): | IN FA | | N | 24 Hours | |
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Ware autopsy findings available prior to completion of cause of death? 10 Yes 2 No Proceeding the Number, will burk for a laure of the laure for a laure of the laure for a laure of the laure for a laure of the laure for a laure of the laure for a laure of the laure for a laure of the laure for a laure of the laure for a laure of the laure for a laure of the laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laure for a laur | ? vn |

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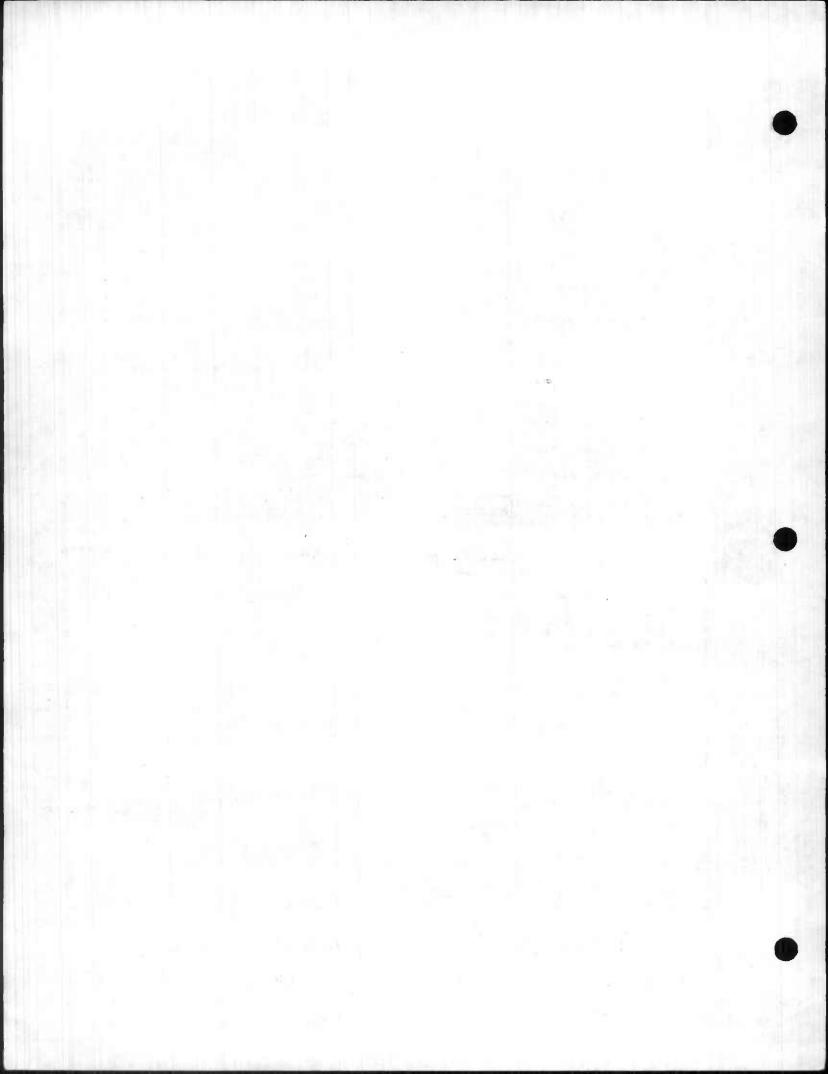
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State of Maryland / Department of Health and Mental Hygien 05364

| | | | | Certifica | te of | Death | F | leg. No. | 0000. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|-------------------------------------|---------------------------|-------------------------------------|-----------------------------------------------|-----------------------------------------|-------------------------------------------------------------------------|
| | 1. Decedent'a Name (First, Middle, Las | | | | • • | | 2. Date of Dea Month | th | 3. Time of Death |
| Physiciai /Medica | MUELLE | . I | Bolton | | | | February. | | 8:17 am |
| Examine | de Carille Name (Mant Institution of) | e street and number) | | | 1 | tb. City, Town, o | r Location of Death | 4c. County of | Death |
| | Gilchrist Cent | er For Hosp | oice Ca | re | | Towson | | Balti | imore |
| Funeral | 5. Social Security Number 6. S | ex 7. Age (| In yrs. last birtl | Months | 7 1 Year Days | If Under 24 Hr Hours Mi | . (Month, Day | Year) 9. | Birthplace (Stele or Foreign Country) |
| Director | 234-74-3859 | L M ZAN | 53_Y | rs. | | | June 3, | 1946 V | West Virginia |
| 2 | Usual Residence of Decedent 10s. State 10b. County | 1 | 0c. City, Town | or Location | | | | | 10d. Inside City Limits |
| faryta f abov | N 2 2 2 2 2 27/1 | | | timore | | | | 1 S Yes 2 No | |
| 28s | Mary Land N/A | 1 | Dar | | o Code | | | 0g. Citizen of Wha | •• |
| | | nuo | | | 1210 | | | United S | |
| A 22 M | 11. Marital Status 1 Never Married 2 12 Married | 12. Was Decedent Eve | er in U.S. | | | | Specify Yes or No- | | American Indian, |
| 5 22 2 | 1 Never Married 2 Named 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2☐XNo If Yes, Give Year or Dates: | | | | Specify: | (Specify Yes or No- into Rican, etc.) | | White, etc. |
| O S S S S S S S S S S S S S S S S S S S | | | 16a. I | Decedent's Usu | el Occup | ation | | 16b. Kind of Busin | ess/industry |
| 215 | (Specify only highest gra | de completed) | | Give kind of wo | ork done i ise retired | during most of w | orking | | |
| Para Para Para Para Para Para Para Para | Elementary/Secondary (0-12) | College (1-4or 5+) 5+ | S | peech I | hera | pist | | Baltimore | e City Schools |
| D della | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Na | ame (First, Middle, | | |
| die die | Sandy Cra | awford | | | | Kath | erine | Perry | |
| Maryland 21215-0020 22 should be filled within 72 hours at h and Mental Hygione. 7 is marked other than "celtural", or traumetic event, the Medical Exam | 19a, Informant'a Name/Relationship (1 | | | | | | Rural Route Numbe | | ate, Zip Code) |
| _ 요일하는 | F. David Bolton/ H | | | , | | | Baltimo | re, MD 2 | 21210 |
| O S C C C C C C C C C C C C C C C C C C | 20a. Method of Disposition 1 Strial 2 Cremation 3 | Removal from State | 20b. Plece of cemetery | Disposition (Na r, crematory or | me of other piec | >e) | Date | 20c. Location - Cit | y or Town, State |
| Page Page | 4 Donation 5 Other (Specify | | Mt. Gi | lead Ce | mete | ry | 2/21/00 | Reisterst | town, MD |
| Baltimore permit. Pages 1.1 Department of Hs important: if Hsm any injury or oth angles. | 21. Signature of Funeral Service Licen | 1 | | CAFA | Step | ss of Facility hen D. | Lohrmann res Drive | P.A. | MD 21206 |
| | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | ourdesty | e death. Do no | | | | | | Approximata |
| Physician | | | | | | | | | Interval Between Onset and Death |
| /Medical | Immediate Cause (Final | (a) able | Man | M | Make | amo- | | | UNKNOWN |
| Examiner | disease or condition resulting in death) | · Ghoble | e to (or as a c | onsequence of) | | 01 | | | |
| | | 0 | 0 10 (01 23 0 0 | orisoquerioe ory | | | | | |
| death certificate be executed extraording physician and of for use as the burial-transit | Sequentially list conditions. | b | e to (or as a co | onsequence of) | : | | | | |
| O and | | | | | | | | | |
| . 68760, rifficate be ax og physician es the burla | that initiated events resulting in death) Last | CDu | e to (or es e co | onsequence of): | | | | | |
| \$ 0° | | | | | | | | | |
| BOX eath cer attendin | | d | | | | | | | 1 |
| P.O. BOX of the death cer d by the attendir eteched for use | Part II. Other significant conditions or | ontributing to death but n | ot resulting In | the underlying | cause giv | en in Part I. | 23b. Did to | obacco usa contri | bute to the cause of death? |
| O d ty the | | | | | | | 1 U Y | aa 2 No 3 | Probably 4 Unknown |
| 6 5 6 A | | | | | | | - | T | |
| The lew requires the the sate has been signed by the page 2 should be detected. | | | | | | | 24a. Was a perfor | | 24b. Wera autopsy findings available prior to completion of cause |
| Pas pas pas pas pas pas pas pas pas pas p | | | | | | | | | of death? |
| Hata hata hata hata hata hata hata hata | | | | | | | 1 🗆 Y | es 2 No | 1 ☐ Yes 2 ☐ No |
| Vital Residents That I contificate he lirector, page | 25. Was case referred to medical | | | | | | eeth (Check only or | ne) | 10 |
| F 2 2 2 | 1 Yes 2 No | | 2□ ER/Out | - | _ | 4LI Nursing | Home 5 ☐ Resid | | |
| C 2 25 6 | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Y | ear) 28b. Ti | | 28c. Injur Wor | | 28d. Describe h | ow Injury occurred | |
| DIVISION of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of th | 2 Accident investigation 3 Suicide 6 Could not be | | | М | 10 | Yes 2 □ No | | | |
| IVI herd herd herd herd | 3 Suicide 6 Could not be determined | 28e. Place of Injury building, etc. (| At home, fan Specify) | m, street, factor | y, office | | 28f. Location (S City or Tow | | or Rural Route Number, |
| D SECTION OF | | 1 | | | | | | | |
| DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam | raician: To the best of miner: On the basis of ex | aminetion and | death occurred for investigation | et the tin | ne, date and place pinion, deeth oc | ce, end due to the c curred at the time, o | euse(s) and mann lete and place, and | er as stated. If due to the cause(s) |
| the the mple | | and manner stated | 1. | | o Linon- | e number | | 9d. Date signed (F | Month Day Veer |
| 5.¥5.8 | 29b. Signature and title of certifier | Inn | | 29 | | 30433 | • |) R |) () |
| | 100.00 | 70 4 | | | 1) | 70 777 | | 2010 | / V |
| 1 | 30. Name and address of person who o | completed cause of deat | | HARLUS S | (1 | Ru- | MURE | MO | 21204 |
| | 21 Date filed (Month Day Year) | 32 82 | Signature | ATTAICLE S | 31 | · 4L | INVE | , ,,, | 100 |
|) State | FEB 2 2 | Z000 | ونشرم | A | 100 | 1 | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Z:15 PM 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 2. Dete of Dest.

Per Druary 16, 2000

Mation of Deeth 1c. County of Deeth Battle Curtis 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Baltimore Baltimore Kehabilatation and Extended Care 7. Age (In yrs. lest birthday) If Under 1 Year Months Deys If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dev. Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 1€M 2□ F Hours N.C. 213-36-1121 59 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location XYes 2□No Baltimore MD NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21216 U.S.A. 2821 Clifton Ave 12. Wes Decedent Ever In U.S. Armed Forces? 1 1374'es 2 □ No If 14'es, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, 11. Meritel Stetus Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Black Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mass Transit Admin. Driver 4th grade 18. Mother's Neme (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Eva Taylor William Gordon Battle 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 20b. Place of Disposition (Name of cametery, crametory or other place)

2821 Clifton Ave, Baltimore Md
20c. Location -Dean Jones-Sister 21216 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2-23-00 Owings Mills, Md Garrison Forest Vet 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility
March F/H West 10 21215 4300 Wabash Ave, Baltimore Md 1 Pent1. Err er the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) 3 years Stroke Due to (or es e consequence of): Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 € No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner?

1 Yes 2 1 Ho 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

Physician /Medical Examiner

Physician

* /Medical

Examiner

Director

Funeral

P

Completed

Be

Funeral

Director

7 is marked other than "natural", or frams 23s or 28s-f show traumatic avant, the Modical Examiner must be notilled at

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or ital

permit. Pages 1 and 2 Department of Health a Important: If Itsm 27 Is any Injury or other trait

3altimore, Maryland 21215-0020

the Manyland

Examiner Physician/Medical à Completed Certification: To

1 (Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

sician and burial-transit physician s s the burial signed by t

death. or Attand after death Director: To the Hospital of within 24 hours a To the Funeral Completaly filled

Division of Vital Records, P.O.

Medical

State Registrar 29b. Signetyre and title of certifier ny 29c. License number 00032548

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated.

1 Yes 2 No

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and address of the service of death (Item 23e) (Type, Print) 10 North Creene Street

Rev COLVN MD Baltimore, Maryland

(Item 23e) (Type, Print) 10 North Creene Street

31. Dete filed (Month, Dey, Year) FEB 2 2 2000

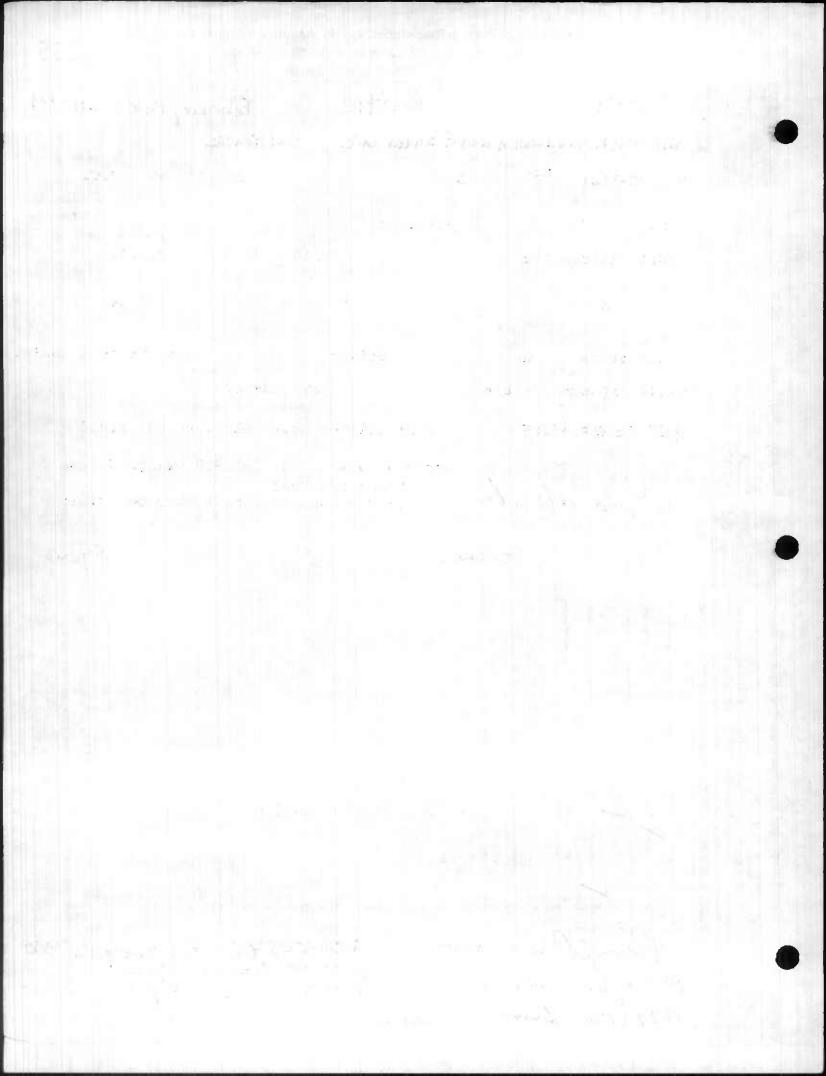
5 Pending

investigation

6 Could not be determined

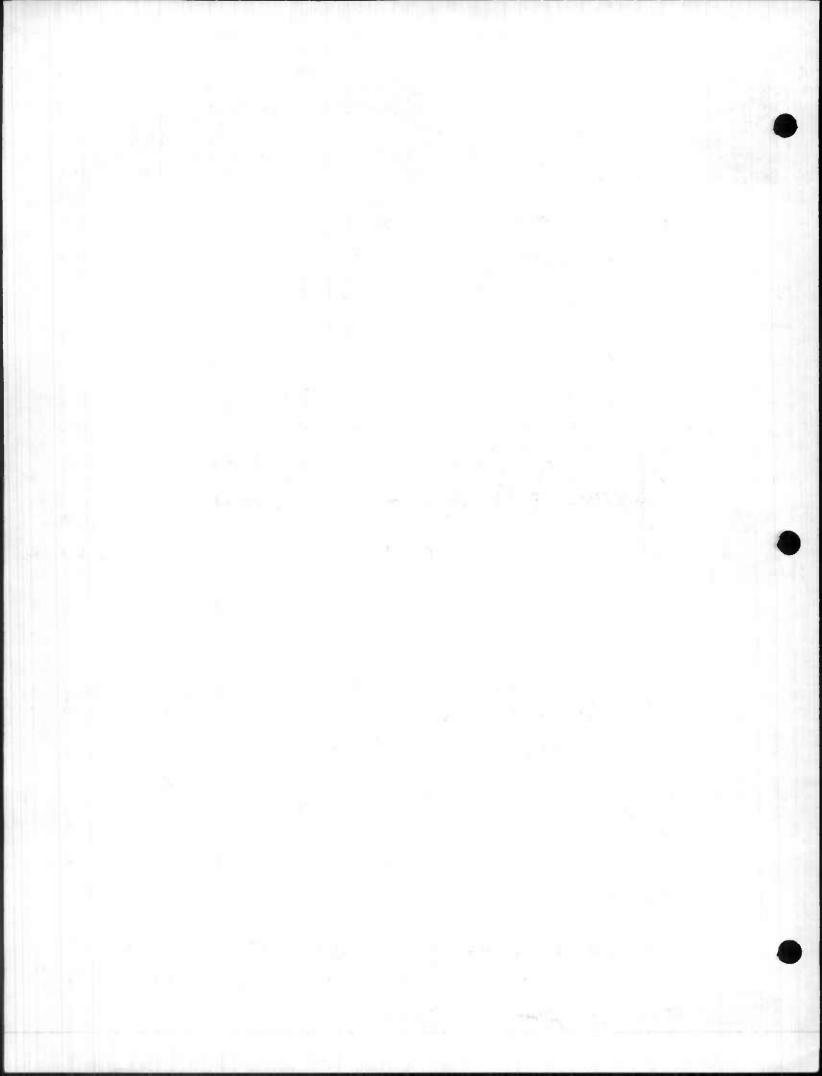
32. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene \(\Omega\)

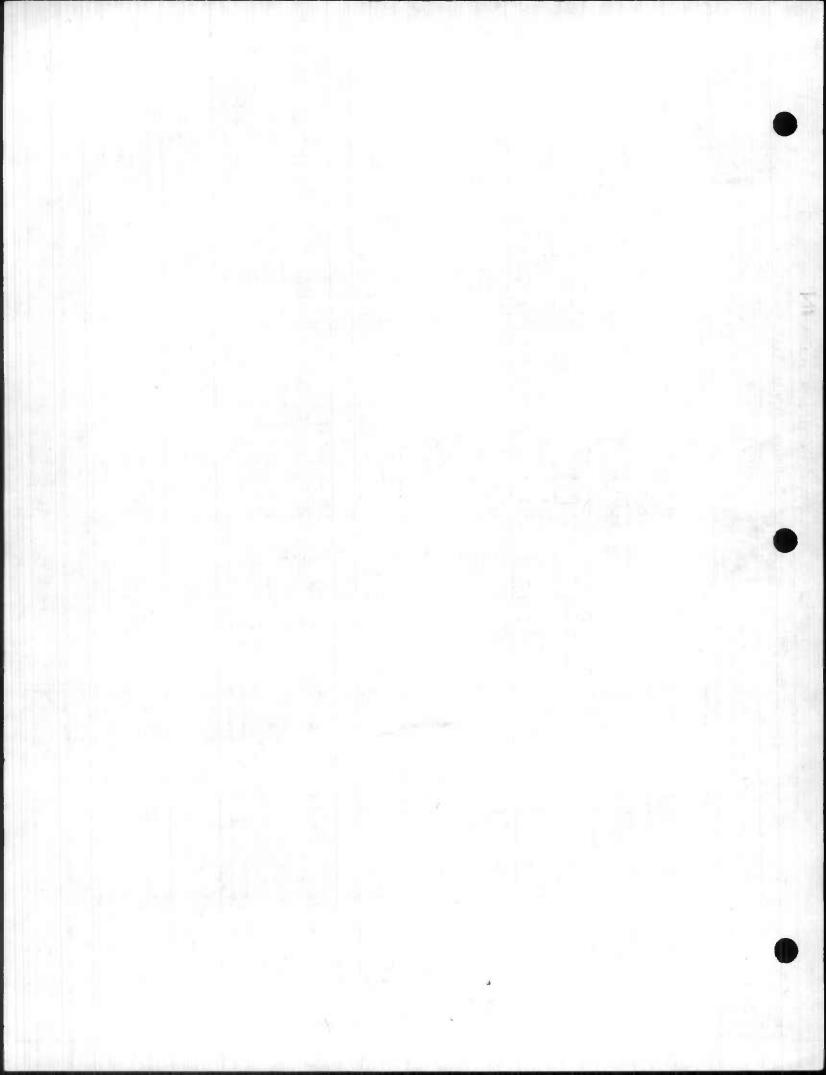
| | | Certificate of Death Reg. No. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dh | | 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death |
| Physic /Med | | Robert Brown FEB 16 2000 0400 |
| Exam | | 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death |
| — | М | Lovien Mursing Home Columbia Howard |
| Funera Directo | | 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) Yrs. 1 Months 1 Days 1 Under 1 Year 1 Under 24 Hrs. Months 1 Under 24 Hrs. Months 1 Under 24 Hrs. Months 1 Under 24 Hrs. Months 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 1 Under 24 Hrs. 2 Under 24 Hrs. 3 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 4 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Under 24 Hrs. 5 Unde |
| anyland | | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits |
| the Maryla 288-1 shor | cto | Md NA Baltimore 12 Yes 2 No |
| vith th | E E | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? |
| eath se 23 | erai | 11. Marital Status 12. Was Dacadent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yas or No- 14. Race - American Indian, |
| d 21215-0020 filed within 72 hours effer death with the Maryland thygiene. ther than "natural", or flems 23a or 28a-f show int, the Medical Exemples. | by Funeral Director | |
| 5-002 72 hours | Pa | 15. Decedent's Education 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry |
| 21215-0020 d within 72 hours ef piene. r than "neturel", or | Completed | (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired) P+J. Construction |
| d 212 filed within Hygiene. ther than ent, the M | E O | 12th grade NA Foreman company |
| Maryland 2 d 2 should be filed th and Mental Hygi f? Is marked other traumatic event, | Be | 18. Mothers Name (First, Middle, Last) |
| larylan | 2 | |
| 2 2 2 2 | | 19a. Informant's Nerfe/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 Spring dale, Avenue Baltond Z1216 |
| Te, N 1 and 1 Health 1 mm 27 | | 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State |
| ages ant of rt: If h | | 1 Burial 2 Cremetion 3 Removal from State Cemetery, crematory or other place) 4 Dogration 5 Other (Specify) Mt 71110 CMotory 7-22-00 Lansdown Md |
| Baltimore, hepemir. Pages 1 and Department of Health Important: If Itam 27 any Injury or other the once. | | 21. Signature of Funeral Service Licenses 22. Name and Address of Facility / 1/2/5 |
| Balt permit. Depart Import | | Illime + James March F. H. Waltach Avenue Balto ud |
| | | 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. Approximate |
| Physician | | shock, or heart feiture. List only one cause on each line. |
| /Medical Examiner | | Immediate cause (Final disease or condition resulting id death) 2 Wloks |
| 1 | | Due to (or es e consequence of): |
| ped hed | Examiner | b |
| Box 68760, eath certificate be executed attending physician and for use as the buriel-transit | Exal | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): |
| 68760, ificate be example of the buriel | edicai | Cause (Disease or injury that initiated events |
| c 68 artifica ing ph | | Tesuring in death) Cast |
| Box lath cert attendin for use | Physician/N | d |
| P.O. I that the de deteched i | ysic | Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? |
| IS, P.O es that the igned by the | | Lischemic Colitic. 10 Yee 20 No 30 Probably 4 Wunknown |
| Vital Records, P.O. Box idelan: The law requires that the death cert certificate has been signed by the attendin rector, page 2 should be deteched for use | d by | COLO CI De 24a. Was an autopsy 24b. Were autopsy findings |
| s been si | Completed | end stage land Disease performed? available prior to compilation of cause of death? |
| I Rec | E | 1 Yes 2 No 1 Yes 2 No |
| f Vital Pysician: The securificate director, pag | Be C | 25. Wes case referred to medicel axaminer? |
| of V Physic this ce | To | 1 Yes 22 No Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Rasidence 6 Other (Specify) |
| ng Ph Mer th | on: | 27. Manner of Death 12. Naturai 5 Panding (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? |
| Vision of Vita Attending Physician: if death. ector: After this certific by the funeral director, | cati | 2 Accident Investigation M 1 Yes 2 No 3 Suicide 6 Could not be |
| Division of or attending Physeler death. Director: After this in by the funeral of | Certification: | 4 Homicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) |
| Division To the Hospital or Attanding Is within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral | edical C | 29e. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2. Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
| To the To the comple | Me | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) |
| | | Dougray P. Sheen, MD DO052940 FEB 16 2000 |
| 7 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |
| U | | SANITAY 1. SHAH, MD 10805 HICKONY LIDGE #210, MD 21044 |
| St Regist | ate rar | 31. Date filed-(Month, Day, Year) 32. Registrar's Signature |



State of Maryland / Department of Health and Mental Hygiene

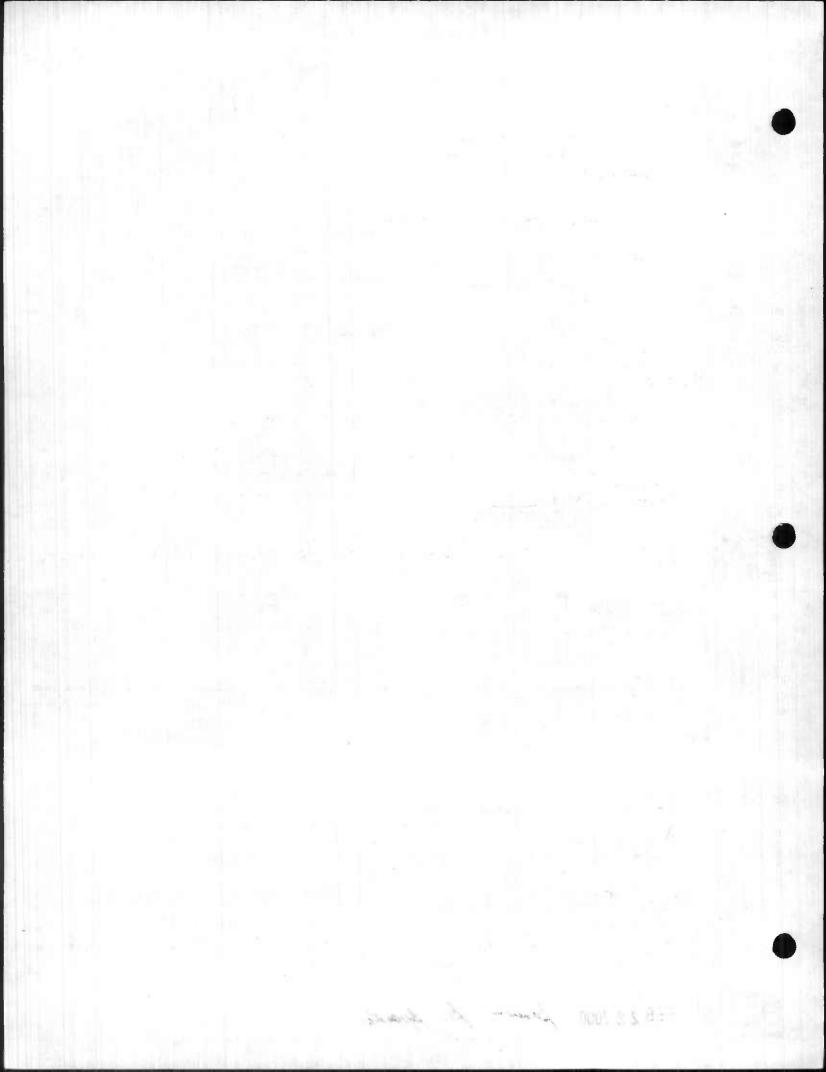
| ician | | ecedent'a Name (First, Middle, La | ıst) | | | | | 2. Date of 0 | Day | Year | 3. Time of Death | |
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| it r | 5. Se | ocial Security Number 6. 5 | | e (In yrs. las | Yrs. If Ur Mont | nder 1 Year ths Deys | | in. (Month, I | Day, Year) | 9. Birthol Coun VIRG | lace (State or Forei | |
| | 2,7,4 | at Residence of Decedent State 10b. County | | 10c City | Town or Location | | | | | 14 | 0d. Inside City Limi | |
| io | | ARYLAND ANNE AR | UNDEL | | BURNIE | | | | | | 1 ☐ Yes 2 ₺ N | |
| al Director | | Street and Number 8 NEW JERSEY AV | E., N.W. | | | Zip Code 1061 | | | 10g. Citizen o | of What Coun | • | |
| by runeral | 1 | Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Armed Forces? 1 1 Yes 2 1 H If Yes, Give Year or Dates: | VO. | 1□ ∨e | | dispanic Origin? an, Mexican, Pu Specify: | (Specify Yes or I lerto Rican, etc.) | No- 14. R B | lece - America leck, White, of cify: | | |
| | | 15. Decedent's E (Specify only highest gra lementary/Secondary (0-12) | ducation ade completed) College (1-4or 5 | | life. DO NO | work done | during most of t | working | | 16b. Kind of Business/Industry | | |
| | - | 12 | | | FOREMAN | | 40 14-11-4-1 | 1 10°7 1 8 8°-4- | DAIRY | .=-1 | | |
| 900 | | Father's Name <i>(First, Middle, Last</i> ALTER THOMAS BL) | - | | | | | Neme (First, Midd E MAGNOL) | | | | |
| 1 | _ | Informant's Name/Reletionship | | | 19b. Meiling Add | race /Street | | | | | Code) | |
| | | ILLANA RAE WOOD | | ER | | | | N.W., G | | | | |
| | | Method of Disposition 1 Byrial 2 Cremetion 3 C | | cen | netery, cremetory N HAVEN | or other ple | | Dete FEB. 2: | 3 | on - City or To | wn, State , MARYLAN | |
| physician and section in the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the p | | Signature of Furieral Service, Lice I. Part I. Enter the disease, or come shock, or heart feiture. List only | aplications that course | the death. | 421 | CRAIN | HWY., S | FUNERAL 1 | EN BURNI | A. CE, MD | 21061 Approximate Interval Between | |
| | resu | quentially list conditions, ny, leading to immediate se. Enter Underlying see (Disease or Injury initiated events ulting in death) Last | 6. ICEHEM | Due to (or a | is a consequence Support the consequence is a consequence | on: | MATHS SUFFICI | | | | | |
| | | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributions. | | | | | | | | | | |
| A IDIO | Pert | II. Other significant conditions of | contributing to death b | ut not result | ing in the underlyi | ng cause gi | ven in Pert I. | 23b. D | id tobacco una | contribute to | the cause of deat | |
| | Pert | II. Other significant conditions of | contributing to death b | ut not result | ing in the underlyi | ng cause gi | ven in Pert I. | | | | o the cause of dead bebly 45 Unknown | |
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| o Be Completed by | 25. 1 | Was case referred to medical examiner? 1 | Hospital: 1 Inpatie 28a. Date of Inju (Month, De) 28a. Place of Inju building, etc. | ont 2 Ei | Bb. Time of Injury M. He, farm, street, feedge, death occur | DOA Ot 28c. Inju Wc 1 Ctory, office | 26. Place of I her: 4□ Nursin ry at rk?) Yes 2□ No me, date and pl opinion, deeth o | 24a. W pe 1 [Death (Check on) g Home 5 □ Re 28d. Describ 28l. Location City or in | as an autopsy riormed? Yea 2 No yone) paidence 6 No yone how injury occur, (Street end Nurown, State) The cause(s) end e, date and place | 24b. We ave con of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th | ere autopsy linding allable prior to mpletion of cause death? Yas 25 No 1/ Route Number, tated. Day, Year) | |

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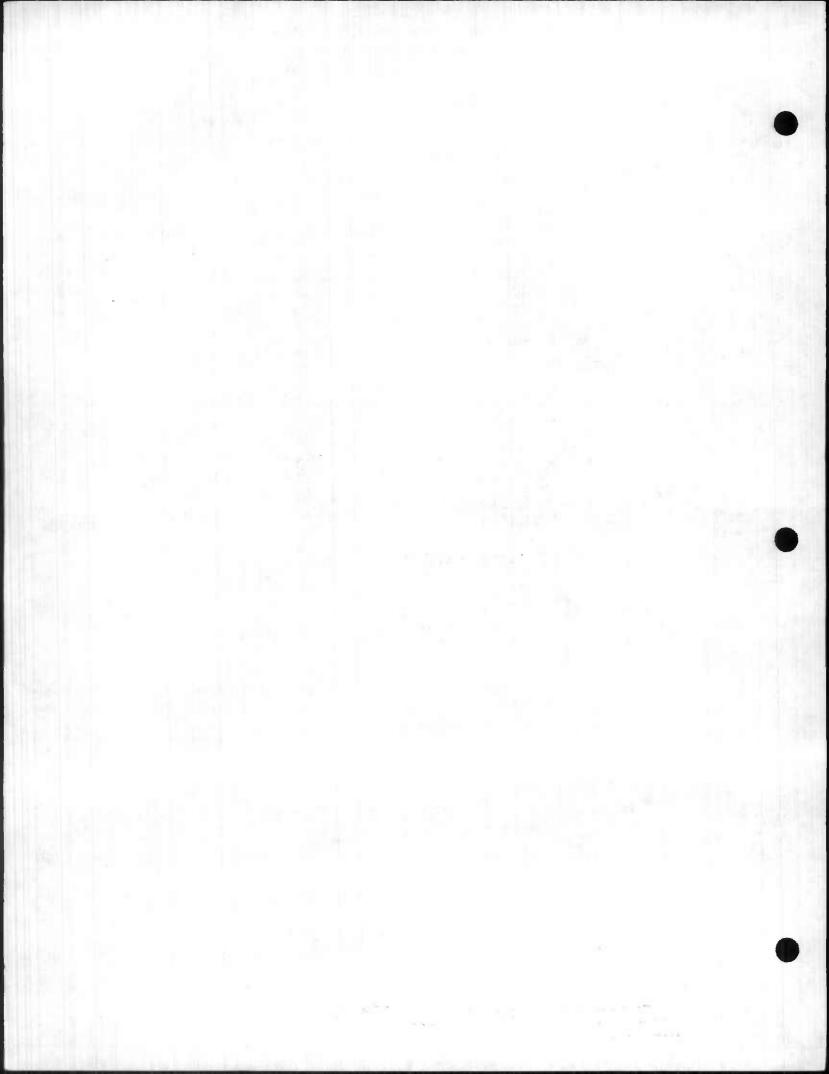
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:30 PM CLARENCE 4b. City, Town, or Location of Deeth D. BOYER 2000 /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Bunse, MD del Mespita ANNE ARUNDEL ff Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Dey, Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 MM 2□ F 75 Yrs Director NOT AVAILABLE MAY 11, 1924 MARYLAND Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits ahow 1 Yes XXNo ma 23e or 28e-f i MILLERSVILLE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 Nerna 23a 844 GENERALS HIGHWAY 21108 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? **LaYes 2 □ No (UN – H Yes, Give Yeer or Detes: KNOWN) Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status hours after 1 Never Married 2 Merried Hygiene. other than "natural", or I ent, the Medical Examir altimore, Maryland 21215-0020 1 ☐ Yes 2 No, Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER SAND & GRAVEL 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BB Pages 1 and 2 should be nant of Health and Mental HOWARD E. BOYER ESTELLE 20 19a. tnformant's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau -LEROY BOYER (BROTHER) 844 GENERALS HIGHWAY, MILLERSVILLE, MD. 21108 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other place) 2/21/2000 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD. 21. Sonature of Funeral Service Licensee 22. Neme and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 avan 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** secondary to alcoholic free dience /Medical **immediate Cause (Final** disease or condition resulting in death) Examiner Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician a the buriel Box 68760, Physician/Medical Due to (or as a consequence of): 8 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 ☐ Yes 2 ☐ No Records. þ been signe should be 24b. Were autopsy lindings available prior to Completed 24a. Was an eutopsy completion of cause page 2 1 Yes 2 No 2000 No certificate Division of Vital or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 205 No Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide filled in 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Certifier Medical within 24 hor To the Fune completely fi (Check only one) ş 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Februa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mon 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 2 Registrar



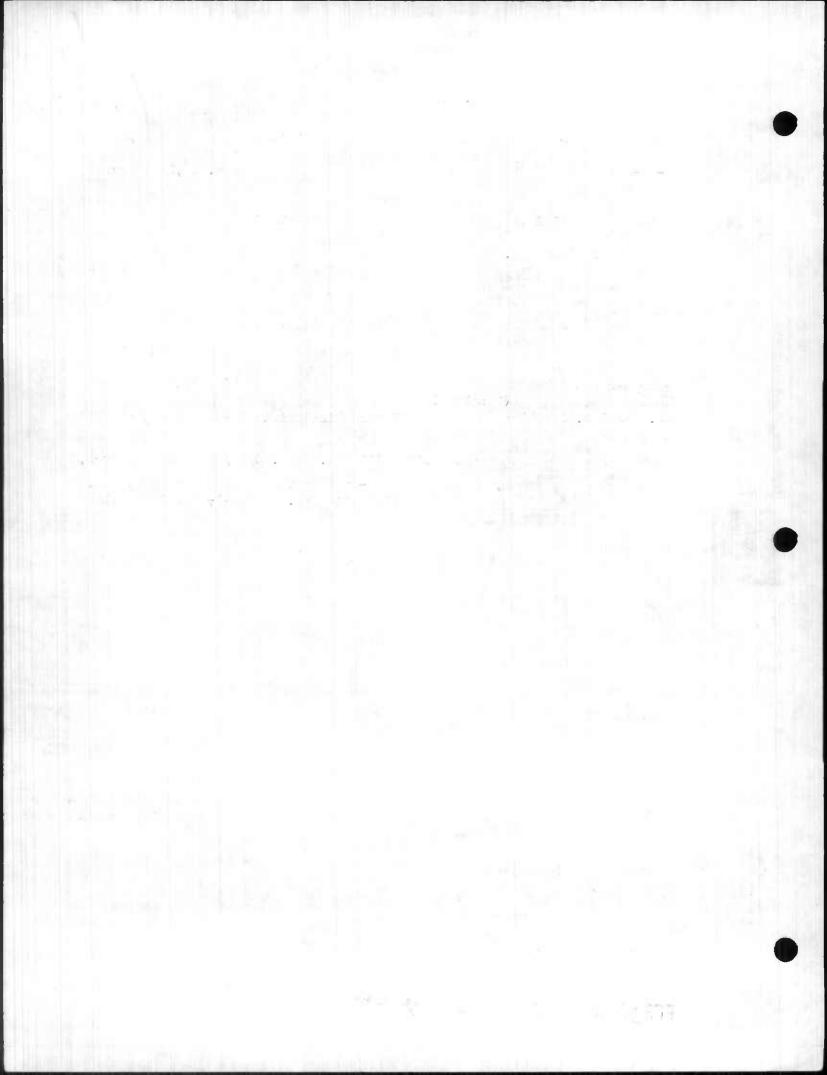
State of Maryland / Department of Health and Mental Hygiene \(\int\)

05369 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month **Physician** Mary G. Bockstie 12:02AM February 18, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Good Samaritan Hospital Baltimore N/A If Under 24 Hrs. Hours Min. If Under 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months 216-05-2892 84 Director June 19, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location r 28a-f show a notified at 10d. Inside City Limits 1 X Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 6201 Loch Raven Blvd. - Apt. 506 Name 23a 21239 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. ther then Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental hygien important: if them 27 is marrised other the any Injury or other transmissions. Bakery Attendant Unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 88 Harry F. Bockstie Anna D. Glos 19a. tntormant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Arthur L. Drager/ Attorney 5 Light Street - Suite 510, Baltimore, MD 21202 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 Buriai 2 □ Cremetion 3 □ Removel from Stete Most Holy Redeemer Cemetery 02/21/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Leonard J. Ruck, Inc. 21. Signetuse of Funerel Service Licenses Christina L. David 5305 Harford Road, Baltimore, Maryland 21214 aurel 23a. Peril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediete Cause (Finei disease or condition resulting in deeth) /Medical Acute Heart Failure Examiner Due to (or as a consequence of): Examiner ASCVD death certificate be executed attending physician and for use as the burial-tran-Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Alzheimer's Disease Box 68760, Physician/Medical thet initiated events resulting in death) Last Due to (or es a consequence of): P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 2 1 Yea 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? has 1 Yes 2 X No 1 Yas 20 No certificate Division of Vitai 25. Was case reterred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 🎇 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 XNo this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Menner of Death 1 Deletural 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner ateted. edical 29e. Certifier /Check only 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) trulleponson, M.D D0013649 February 18, 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Nestor M. Carmona, M.D., 6012 Harford Road, Baltimore, Maryland 21214 31. Date tiled (Month, Day, Year) . Registrer's Signeture State FEB 2 2 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 5370

| | | | Certificate of L | Death | Reg. No. | 03370 | | | |
|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------|--|--|--|
| Physician /Medical | Decedent'a Neme (First, Middle, Last) | Anne M. Burns | 5 | Mon | | Year 6 20 6 | | | |
| Examiner | 4a Facility Nema (If not institution, give st | reet and number) | | b. City, Town, or Location of | Death 4c. County of | | | | |
| | Mercy Hosital Hosp | | | Baltimore Cit | 4 | /A | | | |
| Funeral Director | 5. Social Security Number 6. Sex 104-10-5818 | M 2 F 7. Age (In yrs. last b | Yrs. H Under 1 Year Months Days | Hours Min. 8. Deta Mon. Sept | of Birth th, Day, Year) | 9. Birthplace (State or Fore Country) New York | | | |
| ž | 10a. Stala 10b. County | 10c. City, Ton | wn or Location | | | 10d. Inside City Limi | | | |
| or 28a-f show be notified at Director | Maryland Balti | more | D | undalk | | 1 □ Yas 2 🗗 | | | |
| be notified | 10e. Street and Number | anore | 10f. Zip Code | | 10g. Citizen of W | hat Country? | | | |
| | 103 Center Place | Apt. 219 | | 21222 | Unite | d States | | | |
| Saminer m Examiner m by Fune | 11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | 13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2∑No | spanic Origin? (Specify Yes n, Mexican, Puerto Rican, et Specify: | or No- lc.) 14. Race Black Specify: | · Amarican Indian, t, White, etc. White | | | |
| leal feal | 15. Decedent's Educi | ation 16s | . Decedent's Usuel Occupa | ition | 16b. Kind of But | siness/Industry | | | |
| t, the Medical Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | (Give kind of work done d life. DO NOT use retired) | dring most or working | | | | | |
| C the | 12 Years | | Data Process | | Reta | | | | |
| 8 40 | 17. Father's Name (First, Middle, Last) | | | 18. Mothar's Neme (First, A | | • | | | |
| To To | Stephen Matwishy | | | - | e Chornenky | | | | |
| er traum | 19a. Informent's Name/Ratetionship (Type Mrs. Carol S. Beac | chley | b. Mailing Addrass (Street a 477 Yorkshir | e Drive Seve | | | | | |
| nt. If ther rry or oth | 20a. Method of Disposition 1 Burial 2 Cremetion 3 Re 4 Donation 5 Rother (Specify) | movel from State | of Disposition (Name of ery, crematory or other place Lly Hill Mem. | | | River, MD | | | |
| Importa any inju | 21. Signeture of Funerel Service Licensee | 4 | | s of Fecility Funeral Home Ave. Dundall | | | | | |
| | 23a. Pert . Enter the disease, or complic shock, or heart failure. List only one | ations that caused the death. Do | | | | Approximata Intarvel Between | | | |
| ysician fledical aminer | Immediate Cause (Finet disease or condition resulting in death) a Melaslact Colon Canal Due to (or as a consequence of): | | | | | | | | |
| physician and the burial-transit edical Examiner | Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | consequence of): | | | | | | |
| 0 0 | thet initiated events resulting in death) Last | Due to (or as a | consequence of): | | | | | | |
| of the Car | The H. Call and L. Marian and Marian | | | | mu a na na na na na na na na na na na na n | 1 | | | |
| ed by the attending detached for use a | Part II. Other eignificant conditions control ESOPHAGEA | ibuting to death but not resulting | in the underlying cause give | n in Pert I. 23t | 23b. Did tobacco use contribute to the | | | | |
| page 2 should be det | | | | 24a | . Was en eutopsy performed? | 24b. Wara autopsy finding available prior to completion of cause of death? | | | |
| e Pe | | | | | 1 Yas 2 No | 1 Yas 2 No | | | |
| certificate hes rector, page 2 Be Comp | 25. Was case refarred to medical | | | 26. Placa of Death (Check | - / 4 | MARIS Atl | | | |
| 0 D | avaminer? | spitel: 1 Inpetient 2 ER/O | utpatient 3 DOA Othe | | - 1 | or (Specify) Has Dis | | | |
| 5 7 | 27. Manner of Death | 26a. Date of Injury 28b. | Time of 28c. Injury Injury Work | | scribe how injury occurre | | | | |
| he fu | 1 Accident 5 Pending investigation | , and the same | | /as 2□No | | | | | |
| al Director: After to do in by the funer Certification: | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. Place of Injury - At homa, f building, etc. (Specify) | arm, street, factory, office | | ation (Street and Number or Town, Stata) | er or Rural Routa Number, | | | |
| To the Funeral Director: After the completely filled in by the funeral Medical Certification: | 29e. Certifier (Check only one) Certifying Physic 2 Medical Examine | cian: To the best of my knowledger: On the basis of axamination and manner stated. | e, death occurred at the time ad/or investigation, in my op | a, data end place, and dua inion, death occurred at tha | to the cause(s) and mai tima, data and place, a | nner as stated. nd dua to the cause(s) | | | |
| To th | 29b. Signature and title of certifier | | number | 29d. Date signed | (Month, Day, Year) | | | | |
| 4 | Del a The | O M) | D 40 | 854 | FEBRUA | MD 2120 | | | |
| | 30. Name and address of person who com | ipiered cause of death (Item 23a) | (Type, Print) | 11 | | 44 | | | |
| | DAVID RISEDFI | Ra 301,5 | + PAUL PI | BAH | MORF | MD DIDA | | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** BOWEN -RENE, FEBUARY 15, 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NURSERA CARE RUXTON 10WSON BALTIMITE Home If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthoay) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months 10 M 2 F 8 Yrs. 214-16-349 Director MAY 26, 192 Usual Residence of Deceden with the Maryland 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits BACTIMORE 1 Yes 2 HO MD OWSON Directo 288-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code b OPPA RD 21204 U.S. A Nerve 23a 305 Funeral . Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Meritel Status 1 Yes 2 No If Yes, Give Year or Dates: hours after 1 Never Merried 2 Married 6 altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hann of Health and Mental Hygiene. Int if liem 27 is marked other than "nati Elementery/Secondary (0-12) College (1-4or 5+) STATE of MARYLAND 12th SECRETARY 2 455 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Buechler HERMAN AGNES Goenner 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra MD, 21082 MARK.A. 5020 ELDER RD. HYDES DANEKER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Stete 18/2000 Department of Important: If any injury or Cemetery 22. Nome and Address of Facility Friend Home, CHTD. HARTLEY MILLER FRIENDS 4 □ Donation 5 □ Other (Specify) KALTIMETE 21. Signsture of Funeral Service Licensee BAITO MD Janton 7527 HARFORD RD 21234 relea 23a. Psrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Approximate Intervsl Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Box 68760. Physician/Medical for USB BS 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed by 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wss an autopsy performed? page 2 1□Yes 2PNo. 1 ☐ Yes 20 NO certificate Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Diversing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 Nothis 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation or Attending 1 DNatural 24 hours after death.

Funeral Director: Al 1 Tyes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital edical 10 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29s. Certifier (Check only within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of of death (Item 23a) (Type, Print) 30. Name and address of a erson who completed cal Ul

DHMH 16 Rev 6/95

State

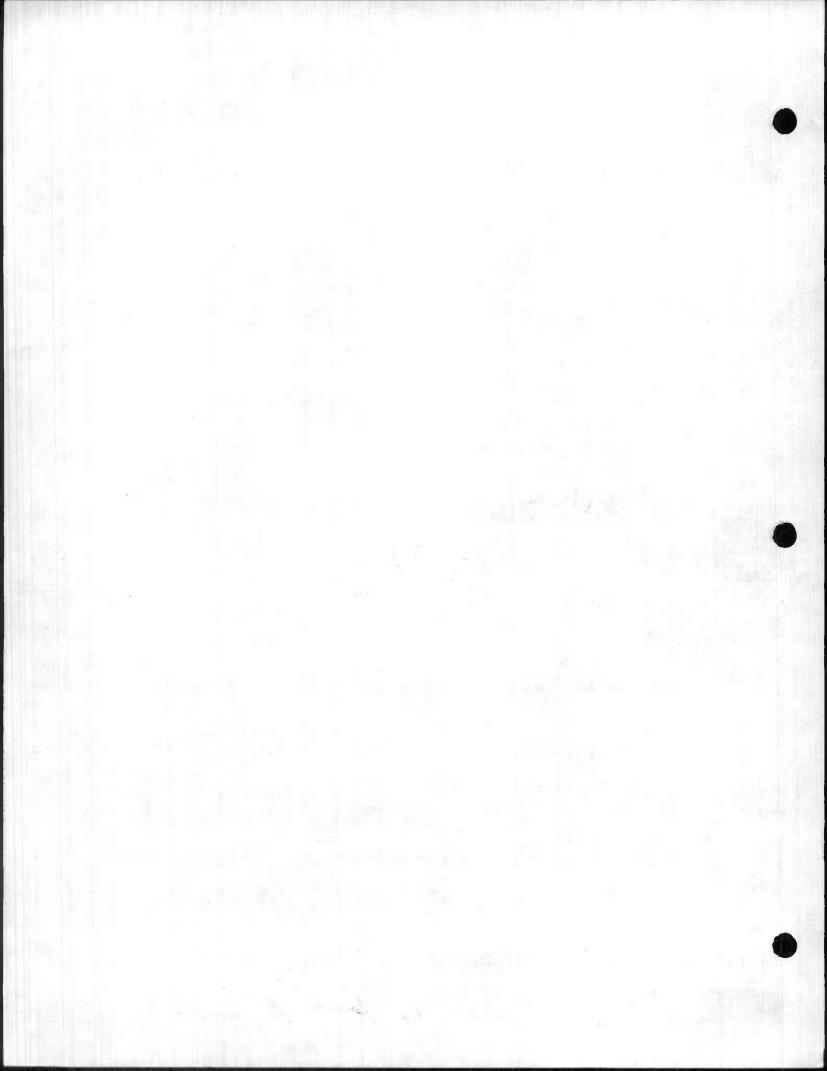
Registrar

31. Date filed (Month, Day,

FEB 22

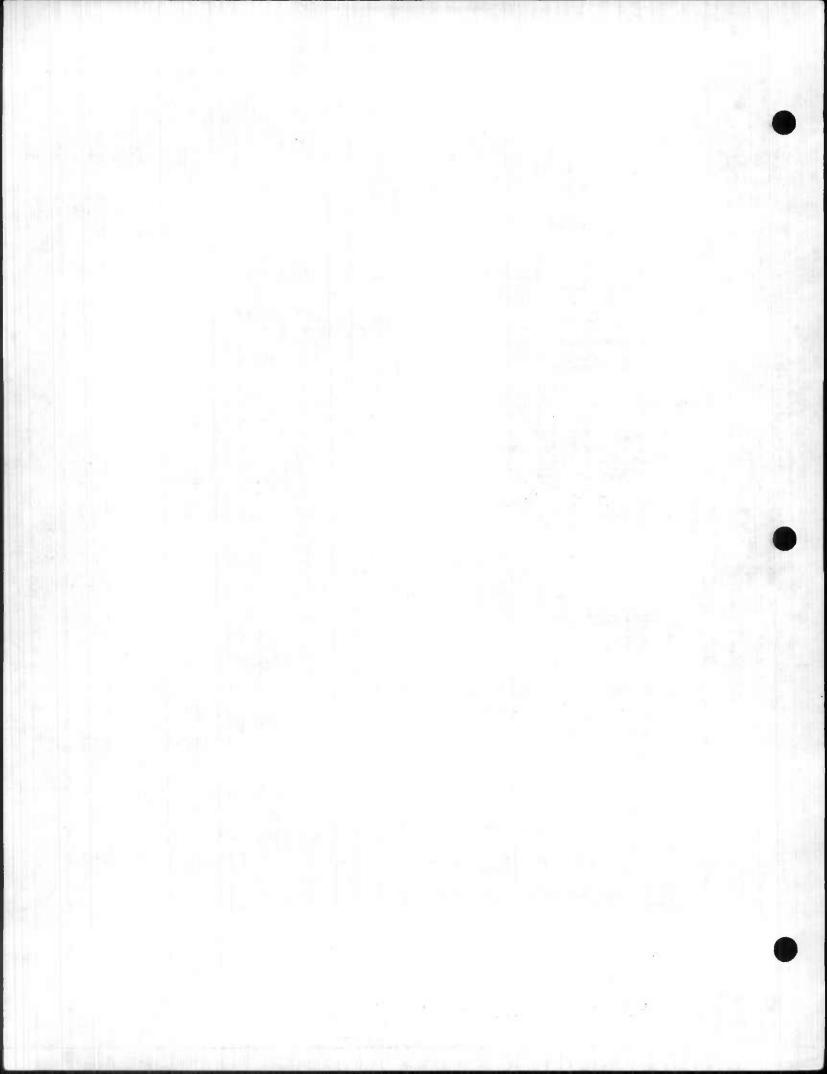
2000

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

| | | | Certificate of | Death | Reg. No. | 05372 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------|
| Physician /Medica Examine | LOKONCE | | BETZ | 4b. City, Town by Location of | Death 4c. County of | ear 3. Time of Death O 2:15AM Death |
| Funeral Director | 5. Social Security Number 6.5 216-16-9167 | DAY U(CA) 7. Age (in yes, to 7.4 | asf birthday) 8 Undar 1 Year Yrs. Months Days | If Under 24 Hrs. 8. Date (Mont | of Birth year) 6/1925 | Birmplace (State or Foreign Country) Maryland |
| Maryland | 10a. State 10b. County | | .Town or Location | | | 10d. Inside City Limits 1 ☐ Yes 2☐No |
| first death with the Mei frems 23e or 28e-fai never ment be notified | 10e. Street and Number 406 Meadow Road | | 10f. Zip Code 2120 | 06 | U.S.A. | |
| d 21215-0020 Illiod within 72 hours after death with the Maryland Hygiena. Hygiena. Hygiena. Inter then "partural", or herms 23s or 28e-f ahow int, the Medical Exercise must be notified as | 3 ☐ Widowed 4 Å Divorced | 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: | 13. Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No | Hispanic Origin? (Specify Yes ean, Mexican, Puerto Rican, et Specify: | or No- c.) 14. Race - Black, Specify: V | American Indien, White, etc. Vhite |
| Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental Hygiena. 7 is marked other than "patural", or traumatic avent, the Medical Energy To Be Completed by | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) | (ucation de completed) College (1-4or 5+) | 16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Security Guar | | 16b. Kind of Busin | |
| E SESS O | 17. Fether's Name (First, Middle, Last) | | | 18. Mother's Name (First, A | | |
| re, Marylan s 1 and 2 should be thealth and Mental thealth and Mental them 27 la marked of | 19a. Informant's Name/Relationship (1) Francis K. Betz J | | | tand Number or Rural Route I Road Baltimore | | |
| Baitimore, North Pages I and Department of Health Important: If I feat 27 and Injury or other transce. | 20a. Method of Disposition 1 □ Burial 2 ဩ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify | Removal from State | l ace of Disposition (Name of ometery, crematory or other pla to/Wash. Crema | | 20c. Location - Cit | |
| Baitimor permit. Pages Department of I important: If he any injury or of | 21. Signature of Funeral Service Licen | 100 | 22. Name and Address 7110 Bela | | Funeral Hon | ne Inc. |
| Settificate be associated from the physician and fine physician and as as the burishment from the physician and from the physician and from the physician and from the physician and from the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the ph | Cause (Disease or injury that initiated events resulting in death) Last | b. COZONAR Due to (or, | as a consequence of): | ESKASK | | FUE YEARS FEFFHEEN YEAR |
| P.O. BOX 6 at the death certific d by the attending stached for use as | Part II. Other significant conditions or | ontributing to death but not resul | iting in the underlying cause gi | ven in Pert I. 23b | . Did tobacco use contri | bute to the cause of death? |
| \$ 55 A | | RUKE | | 240 | 7 | Probably 4 Unknown 24b. Were autopsy tindings |
| 0 > " " | APPER GL | BLEED | | 240 | performed? | eveilable prior to completion of cause of death? |
| = F 4 6 C | | 2CA | | 26. Place of Deeth (Check | 1 Yes 22 No only one) | 1 ☐ Yes 2 ☐ No |
| ion of nding Phys ath. 7: Attacthis as funarsi di | 1 ☐ Yes 2 No | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury Wo | | Residence 6 Other cribe how injury occurred | |
| Division Complete or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Centification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Plece of Injury - At hor building, etc. (Specify) | me, ferm, street, fectory, office | 281. Loca City | tion (Street and Number or Town, State) | or Rural Route Number, |
| Div he Hospital or in 24 hours afte he Funeral Dir pletely filled in | 29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Example 15 Certifying Phy 15 Certifying Phy 16 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Phy 17 Certifying Ph | o the cause(s) and mann time, date and place, and | | | | |
| To the To the comple | 29b. Signature and title of certifier | apakin | 29c. Licen | se number | 29d. Dete signed (| Month, Day, Year) |
| 6 | LISA MARAG | completed cause of death (Items AKIS M.D. V | OhNS HOPKIN | s 600 N. Wolf | ESTREET BY | HEMORE, MARYLAND |
| State Registrar | 31. Date filed (Month, Day, Year) FEB 2 2 2000 | 32 Registrar's Signatu | & South | / | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year CRITZER FEB XOTTIE 3.35 AM 21 2000 4s Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWAKD COUNTY GENERAL HOSPITAL HOWAKD COLUMBIA 7. Age (In yrs. last birthday) If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 5. Social Security Number 6 Sax 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 10 M 20 F 213-28-1886 96 14. 1903 Virginia **Usual Residence of Decedent** 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6605 Pheasant Drive 21075 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yaer or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Merried 1□ Yes 2□ No Specify white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Lee Carter Annie (Unobtainable) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6605 Pheasant Drive, Flkridge, Md. 21075
of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposi Marjorie Schmidt - daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State $^{2/}_{24/_{00}}$ Crozet, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Crozet Cemetery 21. Signature of Fundral Service Licenses 22. Nama and Addrass of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest,

Approximate Approximata Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) DAYS . LEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): ATRIAL FIBRILL ATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yee 2 No 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

/Medical Examiner The lew requires that the death certificate be axecuted Box 68760, P.0. Division of Vital Records,

Physician/Medical Examiner \$ lighed by the attending p þ Completed page 2 8

Physician

/Medical

Examiner

10a, State

MD

Funeral

Director

na 23a or 28a-f ahow must be notified at

then "natural", or home:

filed within 72 hours effer of Hygiens. "neturel", or her

i. Peges 1 and 2 should be filed w tment of Health and Mental Hygler tant: If Item 27 1e marked other th ijury or other traumatic event, the

Department of Important: If eny injury or page.

Physician

physician

21215-0020

Maryland

Baltimore,

Director

Funeral

þ

Completed

the Menyland

Certification: To

certificate has Attending Physicien: After this funeral To the Hospital or Attending Within 24 hours after death.
To the Funeral Director: Aft

> State Registrar

DHMH 16 Rev 6/95

Medical

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

OFFICER HOUSE

28b. Time of

28e. Plece of Injury - At home, larm, street, fectory, office building, etc. (Specify)

110055200

29c. License number

28c. Injury at Work?

1 Yas 2 No

29d. Dete signed (Month, Day, Year) 21 2000 FEB

CEDARLANE COLUMBIA MUZICILY

28f. Location (Street end Number or Rural Route Number, City or Town, Stele)

28d. Describe how injury occurred

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

MURTHY GENERAL HERPITAL, 5755 HOWAKD COUNTY

31. Date filed (Month, Day, Year)

27. Manney of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

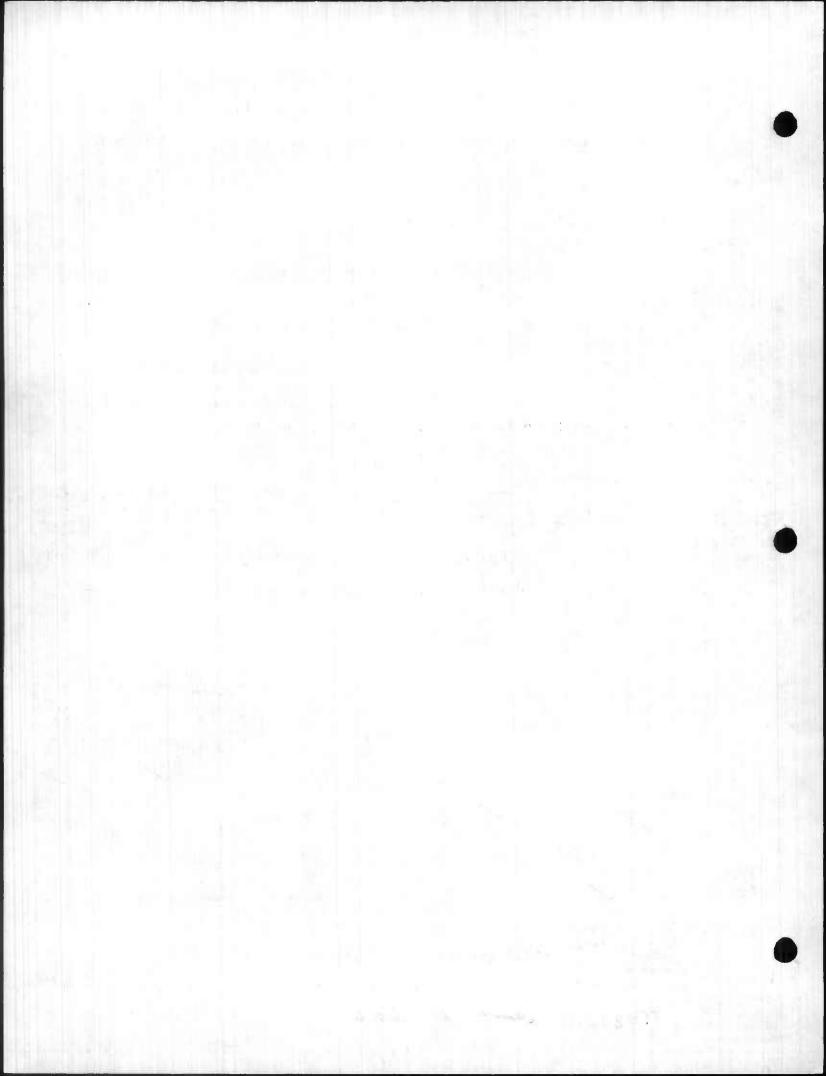
1 DNatural

FEB 2 2 2000

32. Registrar's Signeture

28a. Dete of Injury (Month, Day Year)

oake



| | _ | ER F.H. G7 | | 2000 JAB | e of Ma | aryland / [| | ificate | | | 2. Date of D | Reg. No. | U | 05374 |
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| Physicia /Medic | an al | | | MA | | S COR | RAD | I | | | Month FEB | 19 2 | Year 000 | 6:50am |
| Examina Funeral Director | er ^{4a} | | Care- Number 5384 | n, give street and Ruxton 6. Sex 1 M 20 | 7. Age | e (In yrs. last bir 86 | thday)_ Yrs. | If Under 1 | | TOWSO If Under 24 Hrs. Hours Min. | 8. Date of Bi | В | 9. Birth | more place (State or Forei nity) |
| Aaryland Tahow | | a. State MD | 10b. County Bal | timore | | 10c. City, Tow | n or Loca | ation | E | Ssex | | | | 10d. Inside City Limit |
| h with the A 23a or 28a- | Funeral Director | e. Street and Nu | | in Ave. | | | | 10f. Zip C | ode | 2122 | 1 | 10g. Citizen of | What Cou | ntry? |
| L', o | þ | . Meritel Status 1 □ Never Meritel 3 □ Widowed | - | ried 1 7 | Decedent Ed Forces? Ses 2016 Give or Detes: | 2007 | | as Deceder res, specify | | ispantc Origin? (S in, Mexican, Puert Specify: | pecify Yes or N o Rican, etc.) | 0- 14. Rei Bie Specif | ck, White, | can Indian, , etc. Thite |
| within 72 ho | Completed | Elementary/Seco | cify only highe | nt's Education est grade complete Colleg | tion 16a. Decedent's Usu (Give kind of will life. DO NOT L | | | nd of work | done d retired | during most of wor f) | king | 16b. Kind of 8 | usiness/In | |
| ould be filed with Mental Hygiene, arked other than atic avent, the | 70 Be C | 12th Father's Name Loui | | 1110 | 00924 | price | 18. Mother's Nen | ne (First, Middle na Duli | e, Maiden Sumer | | | | | |
| 1 and 2 should Heelth and Men am 27 is marke ther traumatic | | Louis Arpin 19a. Informant's Name/Reletionship (Type, Print) Roselie Zurlo / daughter | | | | | | | | and Number or Ru | ral Route Numi | | | p Code) |
| pemit. Peges 1 and Department of Heelth Importent: If Itam 27 any Injury or other to poss. | | a. Method of Dis 1 Suriat 2 4 Donation 1. Signature of Fu | Cremetion 5 Other (S | cemeter | tice of Disposition (Name of metery, cremetory or other place) 11y Redeemer Cemetery 2/22/2000 Baltin 22. Name and Address of Facility | | | | | | | | | |
| Physician /Medical Examiner | niner lu | 3a. Part1. Enter shock, or hes numediate Cause seasa or conditions willing in death) adjusted the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the season of the se | (Finat on | r complications the only one cause of a | Tro | the death. Do ne. The man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and the man and | consequ | the mode of | Mac dyin | y Funera e AVe. B g, such as cardiac | altimor or respiratory | e Md. 2 | 1221 | Approximate Intervat Between Onset and Death |
| 4 4 5 | Cal | any, teeding to in luse. Enter Unda ause (Disease or at initiated event, suiting in death) | erlying injury s | c | C | Due to (or as a c | conseque | ence of): | | | | | | 1- 11 |
| that the deat ed by the att detached for | | rt It. Other signif | ficent condition | one contributing t | o death bu | rt not resulting in | the unc | lerlying cau | se giv | en in Part I. | | tobacco use co | | to the cause of deat |
| S S C | Completed by | | | | | | | | | | 24a. Wa | s an autopsy formed? | av CC | Vere autopsy findings vailable prior to ompletion of cause f death? |
| siction: The law s certificate has b sirector, page 2 s | | . Was case refer | red to medica | ıt | | | | | | 26. Place of Dea | | Yes 2 No | 1 | ☐ Yes 2☐ No |
| F 15 1 | 9 | examiner? 1 Yes 2 Manger of Deat Natural Accident Suicide Hornicide | | gation not be 28e. Pl | Inpatier ate of Injury Nonth, Day tace of Injury uilding, etc. | y Year) 28b. 1 | Time of njury | М | | er: 42/Nursing H | ome 5 Res 28d. Describe | sidence 6 Otto | rred | rel Route Number, |
| apital hours a meral C | | e. Certifier (Check only | | Examinery On th | e basis et | Exemination and | | | | ne, date and place pinion, deeth occu | | | | |
| P. Fu | 29b. Signature and talk of certifier 29c. License number 29d. Date signed (Month, Dey, You | | | | | | | | | | | , Dey, Year) | | |
| To the Hospital within 24 hours a To the Funeral I completely filled | | 1 | 4./ | RE | | | | | | 1391 |) | 4 21 | 100 | |

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 00 05375

| | | | | | Certific | ate of Death | Re | g. No. | | , , |
|------------|-----------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------|--------------------------------------------------------------|------------------------------------|---------------------|-----------------------------------------|----------------------------|
| ш | 16666 | 2 | 1. Decedent's Name (First, Middle, Last, |) | | | 2. Date of Death | 1 | | ne of Death |
| я | Physic /Medi | | Issac | Ch | estaut | _ | Februar | Day 14. 2 | Year | 255 PM |
| | Exami | | 4e. Fecility Neme (If not institution, give | | 1. (00) | | r Location of Death | 4c. County | | |
| | | | Mariner Ho | ealth | | 6 len B | umie | Anne | - Aruno | 101 |
| | Funeral | Г | 5. Social Security Number 6. Sec | x 7. Age (In yrs. | lest birthdey) il Ur Mont | der 1 Year If Under 24 Hi | | | 9. Birthplace (St. Country) | |
| в | Director | | 416-36-8283 Usual Residence of Decedent | 73 73 | Yrs. | Days Hours IVIII | 04 08 | 26 | A.L. | |
| | pu . | ١. | Usual Residence of Decedent 10a. State 10b. County | 10c C | ity, Town or Location | | | | | do Otavi Lisadas |
| | anyla shon | <u>ا</u> | | | | | | | | de City Limits Yes 2 No |
| | he M | Director | MD Baltim | nore S | everna P | | | | | 700 Z XX 110 |
| | hours after death with the Maryland luret, or items 23a or 28a-f show at Example man be notified at | | 10e. Street and Number | | 101. | Zip Code | 10 | g. Citizen of W | met Country? | |
| | a 23 | a a | 104 South Jenni | ings Road 12. Wes Decedent Ever in U | Tro III o | 21146 | | 7 | S.A. | |
| | in the | Funeral | | Armed Forces? | | scedent of Hispanic Origin? (specify Cuban, Mexican, Pue | rto Rican, etc.) | | - American India k, Whita, etc. | n, |
| 20 | rs aft | by F | 1 ☐ Never Married 2X Merried 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 【ANNO If Yes, Give Year or Dates: | 1 □ Ye | s 2[XNo Specify: | | Specify: | | |
| 21215-0020 | 72 hours "naturel", | | 15. Decedent's Edu | | 16a. Decedent's L | Isual Occupation | 11 | 6b Kind of Bu | Black siness/Industry | |
| 115 | | Completed | (Specify only highest grade | le completed) | (Give kind of | work done during most of w T use retired) | orking | | S COMPAN | V |
| 212 | A CH ON | E O | 6th grade | College (1-4or 5+) | HOLTITE | | | NOT I LIV. | J COMPAN | 1 |
| | be filed tal Hygid d other event, ti | Be C | 17. Fether's Name (First, Middle, Last) | | | 18. Mother's N | ame (First, Middle, M | leiden Sumeme | е) | |
| Maryland | 9 5 5 9 | ToB | Willie Chestnut | | | Julia | Reed | | | |
| ary | d 2 should th and Mer 7 is marke traumatic | | 19a. Intormant's Name/Reletionship (Ty | | 19b. Meiling Add | ress (Street end Number or I | | City or Town, | State, Zip Code) | 1 17 |
| | 5 = 0 = | | Agnes L. Chestr | nut-Wife | 104 S- | Jennings I | Road, Seve | erna P | ark, Mo | d 2114 |
| ore | of Heal item 2 | | 20a. Method of Disposition | 20b. I | Piece of Disposition (| Neme of or other plece) | Date 2 | Oc. Location - | City or Town, Stat | le |
| Ĕ | Page mit If | | XIXBurlel 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) | demover from State | | y Line Cem | 2/22/0 | 0 Mint | er, A. | L. |
| Baltimore, | permit. Pages 1 Department of H Important: If its any injury or ot once. | | 21. Signature of Funeral Service License | 00 | 22. Name | and Address of Facility | , | | | |
| œ | Chep Chep Rung Rung Rung | _ | Marion | Ance | | h F/H West | Dolai | nomo M | 4 212 | 1.5 |
| | - | | Pert1. Enter the disease, or compile shock, or heart fallure. List only or | cations that caused the dea | th. Do not enter the r | Wabash Ave | ac or respiratory arre | st, | Approx | |
| - | Physician | | orioon, or record tandro. Else only or | A A | | 0 11 | 7 | | Onset | and Deeth |
| 48 | /Medical | | Immediate Causa (Final disease or condition | aterio Sil | lewit Ca | edio Vascul | as diseas | u | | |
| в | Examiner | | resulting in death) | Due to (| or as a consequenca | edib Varent on: With Chrom | . 1 + + | / / | 4 | |
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| | and and internal | хап | Sequentially list conditions, | Due to (| or as a consequenca | ol): | | | | |
| 9 | be execut iclan and burial-tran | | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 0 | | | | | | |
| 68760 | and the | edical | that initiated events resulting in death) Last | Due to (d | or as a consequenca | of): | | | | |
| × | op up | 2 | | s | | | | | | _ |
| Bo | desth e attar d for u | Physician | Don II Other staniffered and distance and | A-96 - A1 - A - A - A6 - A - A - A - A - A - A - | | | 001 01111 | | | |
| O. | 0 6.5 | ys | Part II. Other algnificant conditions con | | suiting in the underlyir | ig cause given in Part I. | | | tribute to the car | |
| ٥. | the page | by P | gastric lunce | nome | | _ | 1011 | 2 Z Z NO | 3 Probably | 4 Olikilowii |
| Records, | requires een sign hould be | | / | | | | 24a. Was ar | | 24b. Were auto | |
| 00 | 00 | Completed | | | | | perform | 19d? | availeble p completion of deeth? | |
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| Vital | | 0 | 25. Was case relerred to medical | | | 26 Piece of D | eath (Check only one | | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 243 110 |
| <u> </u> | Physiclen: this certific ral director, | 0 8 | examiner? | lospitei: 1 ☐ Inpatient 2 ☐ | ER/Outpetlent 3 | Other | Home 5 ☐ Reside | | er (Specify) | |
| of | | n: T | 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of | 28c. Injury at Work? | 28d. Describe ho | | | |
| Ö | Attending P or death. ector: After by the funer | atio | 1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation | (MOIIII, Dey Fear) | Injury M | 1 Yes 2 No | | | | |
| Division | | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Piece of Injury - At h building, etc. (Special | iome, larm, street, lac | tory, offica | 28I. Location (Str City or Town | | er or Rurel Route | Number, |
| | rs efter al Dire | Cer | | ounding, oto. (open) | | | | 0.0.0, | | |
| | Hospital 24 hours Funeral itely filled | edical | 29e. Certifier 1 Certifying Phys | elclan: To the best of my kno nar: On the basis of examine | owledge, death occur | ed at the time, dete and piedon. In my opinion, death oc | ce, end due to the ca | use(s) and mai | nner as stated. | use(s) |
| | To the Hospital or within 24 hours efter To the Funeral Dir completely filled in | Med | | and manner steted. | | | | | | |
| | of To | - | 29b. Signature and title of phylities | losmo " | | 29c. License number | | | (Month, Day, Ye | |
| | | | () | 0 | | UTUS | | 911 | 1100 | |
| | 10 | | Name and eddress of person who co | impleted cause of death (iter | m 23e) (Type, Print) | 708 mountain | Rd Pres | donA | MI | 1130 |
| | V | | 31. Per Filed (Month, Den Year) | he last Hegistrar's frien | | John Many Many | C. Push | GEN'A | Md . 2 | 1122 |
| | Sta | te | FEB 2 2 7000" | . Hegistral Salur | man parties | | | | | |

2040 y.

FIGGO I THE OFFICE IN DISCRIBION HIM. ASSURE AN COPIES ARE LEGIDIS. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3, Time of Death 1. Decedeni's Name (First, Middle, Last) 2. Date of Death Physician hastout February 14 2000 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 40. County of Death Examiner GlenBurnie Arundel Hoalth lariner If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) Functal 1₩ 8□ F Yre. Director 08 416-36-8283 10a State 10a. City, Town or Location 10b. Count 10d. Insida City Limits r 28a-1 show Director 1 ☐ Yes 2 ☑ No Baltimore Severna Park 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? from 23a or 2 from must be n South Jennings Road

12. Was Decedent Ever in U.S.
Armed Forces? Funeral U.S.A. 104 21146 11. Marital Statue 13. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Med within 72 hours after 1 (1) Yes (1) Yes (1) Yes, Give Year or Dates; 1 Never Married 2X Married Saltimore, Maryland 21215-0020 ŏ 1 Yes 2 XNo Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Black 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buelness/Industry event, the Me KOPPERS COMPANY Elementary/Secondary (0-12) College (1-4or 5+) HOLTITE 6th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Willie Chestnut Julia Reed 18s. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 Agnes L. (20e. Method of Disposition Chestnut-Wife Jennings Road, Severna Park, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XIXBurlai 2 Cremation 3 DRemovel from State 4 Donation 5 Other (Specify) E.B. County Line Com. 2/22/00 Minter, A.L remont Funeral Service Licenses 22. Neme and Address of Facility March F/H West 4300 Wabash Ave, Raltimore Md I caused the death. Do not enter the mode of dying, such as cardiac Physician Status Epileptius with Chronic Vegetators ofste immediate Cause (Final disease of condition resulting in death) /Medical vaminer Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical 2 Due to (or as a consequence of): Afternoon of for the sa Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? k astric 1 Yes 22 No 3 Probably 4 Unknown 24e. Was an autopsy performed? 24b, Were autopsy lindings available prior to completion of cause of deeth? The certificate 1 Yes 2 10 1 Yes 20 No 25. Was pase referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yas 2 FNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 🔲 inpatient 2 ER/Outpatient 3 DOA 27. Manner-of Death 28a. Date of injury (Month, Day Year) 26b. Yime of 28d. Describe how Injury occurred 5 Pending Investiga 2 Accident I ☐ Yes 2 ☐ No 3 Sulcide 8 Could not be determined 25e. Place of injury - At home, farm, street, factory, office building, etc. (Spearly) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide To the Hospital Within 24 hours To the Funeral If Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as steled.

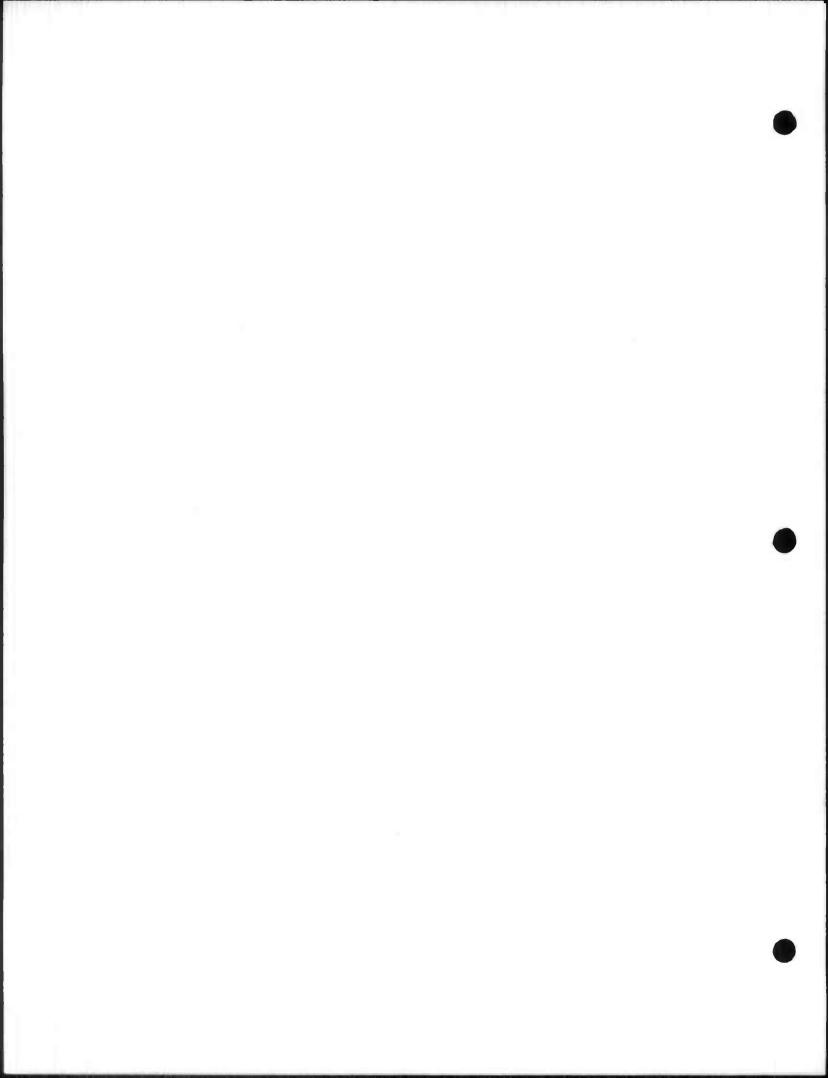
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and manner stated. edica 29s. Cartifler (Check only one) 295, Signate 29d. Dele signed (Month, Day, Year)

State Registrar

tophen

eraon who completed cause of death (flem 23s) (Type, Print) deBori

3708 Mountain Rd. Pasadens Md. 21122



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien€

∩ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Chaliew Chobchean 2 09 2000 10:29AM 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) June 15 19 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 10M 20F Months Hours 579-76-5765 68 Yrs 1931 Thailand Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Montgomery Wheaton 10f. Zip Code 10c. Citizen of What Country? 4015 Adams Drive 20902 Thailand 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Rece - American Indien, Bieck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐XNo Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Neme end Address of Facility

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)

Everly-Crematory

Due to (or as a consequence of)

STAPH AUREUS BACTEREMIA

Due to (or as a consequence of)

Cousenlor/Foreign Ex Student

Funeral Director

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

2

10a. Stete

MD

11 Medial Status

10e Street and Number

3 Widowed 4 Divorced

Elementery/Secondary (0-12)

20e. Method of Disposition

17 Father's Name (First Middle | ast)

Tade Chobchern

19a. Informant's Neme/Reletionship (Type, Print)

15. Decedent's Education (Specify only highest grade completed)

Vilai Srisukontha /Wife

College (1-4or 5+)

4

na 23a or 25a-f show must be notified at then "natural", or items 23s or the Medical Examiner must be a filed within 72 hours after Hygiene. Ther then "natural", or the permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Importants if Nem 27 is marriaed other the any Injury or other tra

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician and for use as the burlal-transit certificate be executed Box 68760. 80 Records, P.O. the signed by the peen has certificate Division of Vital this funeral

Examiner Physician/Medical þ Completed Be To Arter death.

*I Director: After th.

* in by the furedical Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

29e. Certifier 29b. Signature end title of certifier

State Registrar

1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signeture of Funerei Service Licensee 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. PNEUMONIA 1 Yes 2 No

Immediate Cause (Finel disease or condition resulting in deeth)

Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or es a consequence of)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

SEPSIS

PERITONITIS

PANCYTO PENIA 25. Wes case referred to medical examiner?

Hospitel: 1 XInpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 5 Pending investigation t Netural 2 Accident 3 Suicide

4 Homicide

(Check only one)

6 Could not be determined

M.D .

28a. Dete of Injury (Month, Day Year)

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

28c. Injury at Work?

1)35941

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year) FEBRUARY 9, 1000

ROCKVILLE, MD 20852

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

1 Yee 2 No 3 Probably 4 Vunknown

24b. Were autopsy findings available prior to

completion of cause of death?

Asian

Approximate Intervel Between Onset end Deeth

Specify:

18. Mother's Neme (First, Middle, Meiden Sumeme)

2/12/2000

Everly-Wheatley Funeral Home

Chumphee Chobchean

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

4015 Adams Drive Wheaton, MD

16b. Kind of Business/Industry

20902

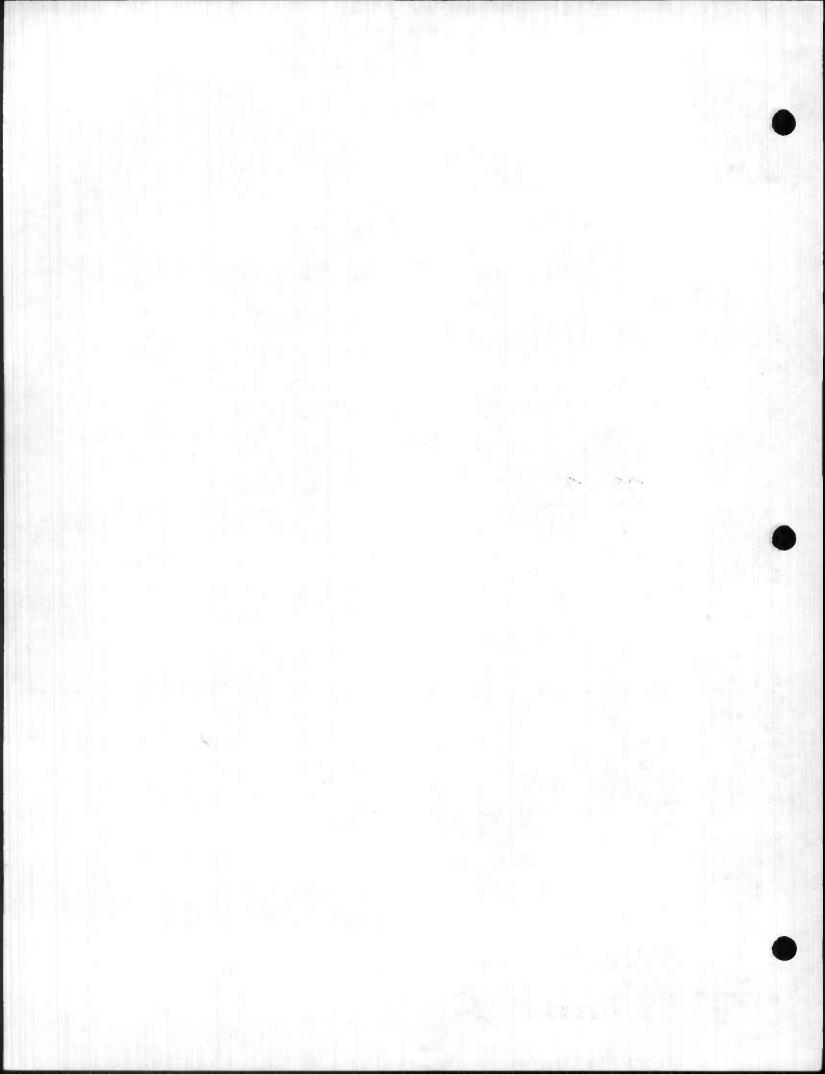
20c. Location - City or Town, State

Alex. VA

Thailand Gov't

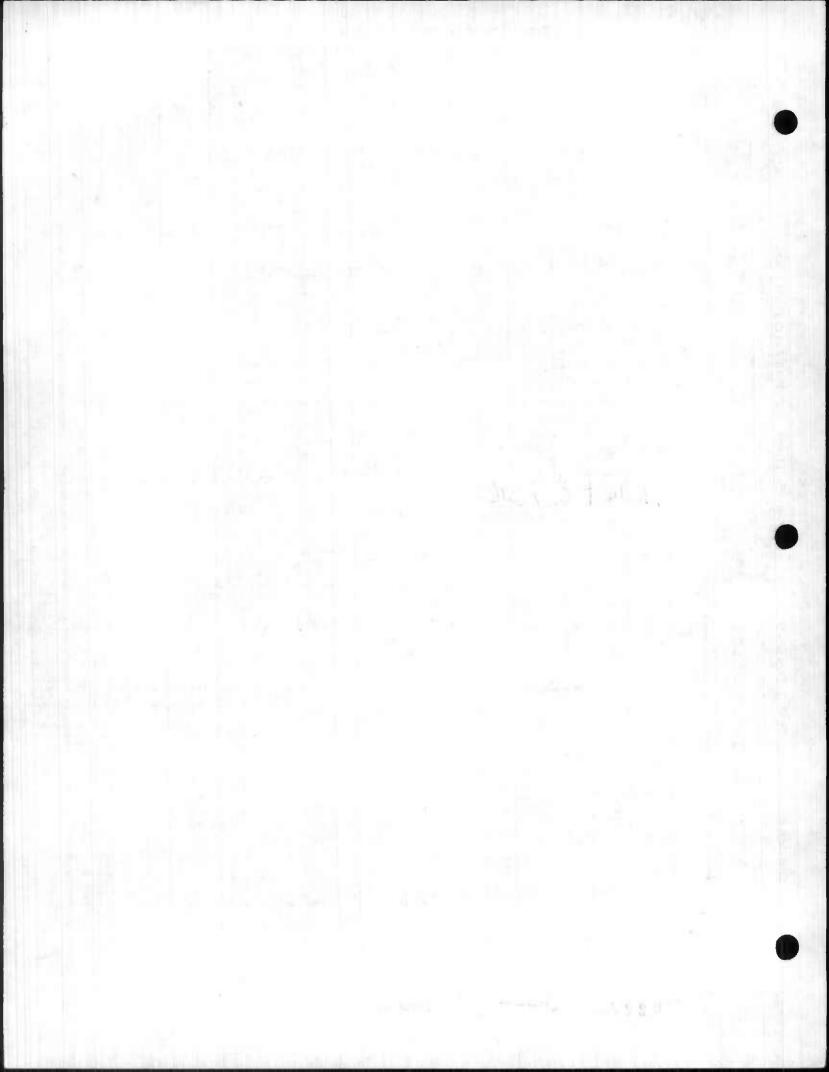
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

PURAN # 401 MATHUR 31. Dete filed (Month, Dey, Year) 2 2 2000 32. Registrer's Signature DENEUL 50 W. EDMONSTON DR.



State of Maryland / Department of Health and Mental Hygiene 00 05377

| | | | | Cer | tificate | of Death | | R | ng. No. | , 0 | 10011 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------|-------------------|-----------------------------------------|--------------------------------------------------|-----------------|-----------------------------------|------------------|--------------------|--------------------------------------------------------------------|--|
| District Control | 1. Decedent's Name (First, Middl | e, Last) | | | | | | 2. Data of Deat Month | h Day | Year | 3. Time of Death | |
| Physician /Medical | OCOOLE | | Chase | | | | | FER | | 200 | 12:15 PM | |
| Examiner | do Englis, Manna Minathatia | |) | | | | imor | cation of Death | 4c. County | | /a | |
| Funeral Director | 5. Social Security Number 218–58–7349 | 6. Sex 7. A | ge (In yrs. last 96 | birthday) Yrs. | If Under 1 \ Months D | rear If Under lays Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day, | Year) | 9. Birthp Court | place (State or Foreign ntry) | |
| 2 | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | | atina | | | | | | Od Inside Oh Alimin | |
| anyle anyle | | | TOC. City, TO | JWII OF LOC | ation | Da1 | timo | 10d. Inside City L | | | | |
| vith the Ma tor 28s-f s be notified | Md. n/a | 2 | | | 10f. Zip Co | | CHIO | | Og. Citizen of V | Mhat Caus | drap. | |
| 23e or | 4017 Liberty He | eights Avenu | æ | | Tor. Zip Co | 100 | | | USA | | | |
| 15-0020 72 hours after death with the Manyland *natural*, or herre 23a or 28a-f show added Evantine must be notified at | 3 Widowed 4 □ Divorced | If Yes, Give | ? | H | /as Deceden Yes, specify ☐ Yes 25 | of Hispanic Ori Cuban, Mexicar No Specify: | i, Puerto I | cify Yes or No- Rican, etc.) | | k, White, | can Indian, etc. ack | |
| 72 h | 15. Deceden (Specify only higher | t'a Education st grade completed) | 16 | Sa. Decede | ent's Usual C | ocupation lone during mos etired) | t of workir | ng | t 6b. Kind of Bu | usiness/Ind | dustry | |
| | Elementary/Secondary (0-12) 12th Grade | College (1-4or | 5+) Ho | omema | | etired) | | Famil | lies | | | |
| be filed to the Hygical and the Co | 17. Father's Name (First, Middle, | Last) | | | | | | (First, Middle, I | | ie) | | |
| arylan should be nd Mentel marked o umatic sva | Eugene Chase | | lo de | | | Jose | phin | e Robin | son | | | |
| e, Maryland 1 and 2 should be the Health and Mental by Health and Mental by Health and Mental by To Ba | 19a. Informant's Name/Retations Frances B. Barl | | | | | | | altimor | | 7 2 2 3 2 2 | | |
| 0 2 2 2 | 20a. Method of Disposition 1 Depurial 2 Cremation 4 Donation 5 Other (S | | ceme | itery, crem | ition (Name atory or othe lemoria | of r place) al Park | F | eb. 19 | 20c. Location - | | | |
| Baltimo permit. Page Department of important: if eny injury or once. | 21. Signature of Funeral Service | E Matte | _ | 22. | Name and A | ddress of Facilit | y Nut | ter Fun | eral Ho | mes, | Inc. | |
| | 23a. Part t. Enter the disease, or shock, or heart failure. List | complications that couse | d the death. D | | | | | | | rica. | Approximate Interval Between | |
| Physician | SHOCK, OF Real Latture. List | only one cause on each | irre. | | | | | | | - 1 | Onset and Death | |
| /Medical | Immediate Cause (Final disease or condition | | Cardia | c 6 | amyt | homios | | | | | 10 minues | |
| Examiner | resulting in death) | e | Cardiac arythmia Due to (or as a consequence of): | | | | | | | | | |
| P = 5 | | 0 | b. Otherwsolante heart disease | | | | | | | | | |
| death certificate be assecuted a strending physician and of for use as the buriel-transit sician/Medical Examines | Sequentially list conditions, if any, leading to immediate | 1/ | Due to (or as | a consequ | uence of): | | | | | | | |
| 68760, fileste be av physician as the burle | | с | Dlobe | ies | mell | ines | | | | | 20425 | |
| 6876 ficate be physicial is the bu | that initiated events resulting in death) Last | | Due to (or as | | | | | | | | | |
| M E E S | | L a. | typa | - Jeon SI | m | | | | | 1 | 1045 | |
| BOX eath cert attendin for use | | | | | | | | 1 1000 -100 | | | | |
| Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Phy | | | | | | se given in Part I | | | s 2 No | | o the cause of death? bably 4 Unknown | |
| The law requires that the rate has been signed by the page 2 should be detached completed by Physics | | | | | | | | 24a. Was a perform | | av | Pere autopsy findings vallable prior to completion of cause death? | |
| CC 2 4 5 5 | | | | | | | | +FIX | s 2 No | | Yes 25 No | |
| Vital sician: Th certificata firector, par | | | | | | 26 Place | of Dogth | (Check only on | | | | |
| of Vita Physician: this certificant director. | | Hospital: t ☐ Inpat | ient 2 FRA | Outpatient | 3□ DOA | I au | | ne 5 Reside | - | er (Sneci | fu) | |
| | | 28a. Date of Inj | | . Time of | | Injury at Work? | | 28d. Describe ho | | | 77 | |
| sion o eath. or: Afferth the funeral | t ☑Natural 5 ☐ Pendin 2 ☐ Accident investi | 9 | ay Year) | Injury | М | 1 Yes 2 | No | | | | | |
| Division of the funer of in by the funer Certification: | 3 Suicide 6 Could determ | inad 288. Place of It | njury - At home, rtc. (Specify) | farm, stre | et, factory, o | ffice | 1 | 28f. Location (St City or Town | | er or Rura | al Route Number, | |
| Division of the Hospital or Attending Ph. Within 24 hours effer death. To the Funeral Director. After the completely filled in by the funeral Medical Certification: | | g Physician: To the best Examiner: On the basis of and manner s | of axamination | | | | | | | | | |
| Nithin Nomp | | | | | 29c. L | icense number | | 2 | 9d. Data signe | d (Month, | Day, Year) | |
| |) De | | | | 1 | 3640 | 74 | | 211 | 7100 | | |
| 1 | 30. Name and address of person | who completed cause of | | a) (Type, F | Print) Bai | hmore | m | D XIZ | 17 | | | |
| State | 31. Date filed (Month, Day, Year) | | rar's Signature | Los | N. I | | | | | | | |
| Donietson | FEB 2 2 2000 | | P. 1 | age of the | - | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** Margaret H. Comegna February 21 10:30am /Medical 4e Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital of Maryland, Inc. Baltimore Baltimore If Undar 24 Hrs. 5. Social Security Number If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 210 F Months Days Hours 84 11-7-1915 Director 215-12-8668 Maryland Usual Residence of Decedent 10a State 10b Counts 10c City Town or Location 10d. Inside City Limits MD n/a Baltimore 1X Yes 2 No Director 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 6013 Glenoak Avenue flams 23s 21214 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien. 11. Merital Status Black, Whita, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify: þ 3 ☑ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglans. Elementary/Secondary (0-12) College (1-4or 5+) In own home 6th Homemaker permit. Pages 1 and 2 should be liled. Department of Health and Mental Hygis Important! Il lesn 27 is marked other is any injury or other traumatic event. B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Jacob Diddlemeyer Sophie Franckowiak 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1248 Narcissus Avenue, Baltimore, Maryland 21237 James H. Comegna 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 2/24/2000 Baltimore, Maryland Most Holy Redeemer 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Fecility Joseph N. Zannino Jr. Funeral Home 263 South Conkling Street, Baltimore, Maryland 21224 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Myocardial Infartini - acute /Medical Immediate Cause (Finel disease or condition resulting in death) Examine Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760, Physician/Medical the Due to (or as a consequence of) 88 use been signed by the atte should be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? pordisin, Hypertenson, atrophic 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other; 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ◯ XER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1□ Yes 2□ No 24 hours after death. 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date aigned (Month, Day, Year) Juberts, Ms D21464 121/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3708 BANK ST BALTO, MIN 2/224 ROBERT LIBERTO, MD.

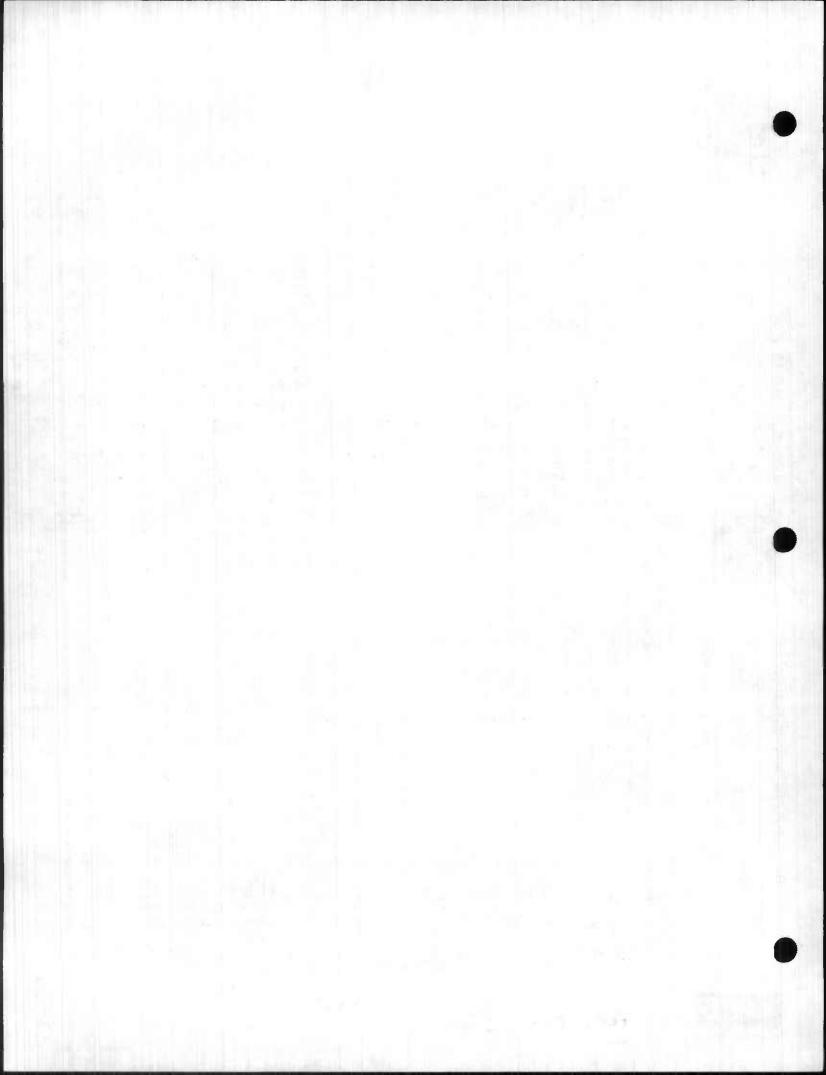
DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

FEB 2 2 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year BEAMICE CARTER CHARLOHE FEB. 2000 16 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Villa St. MICHAEL nursing Home BALTIMOR If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | Months Days 6. Sex Birthplace (State or Foreign Country) Days 10M 20F Hours 65-7671 219 32 Marylano **Usual Residence of Decedent** 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits NA UNIVES 2 No BALTIMORE Marylow 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 925 N. Filton U512 AUG 21217 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2-2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3.25Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME Homomakon 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRY HOPE JONES EthEL BYND 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beltivon, Med 21234 CARTER 2735 CHESLEY ALG 50N KIM 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 2:21-2000 BALTINUE, Monglons LION COMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cil A TWAL - HARRIS PLANWEL HOME 21. Signature of Funeral Service Licenses 50 40 RUSTERSTUWN READ 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or health feiture. List only one cause on each line. nel 21215 Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) neumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2000 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

The law requires that the death certificate be executed P.O. Records, of Vital Division Attending death. after A

Physician

/Medical

Examiner

Director

Funeral

à

Funeral

Director

ahow

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Hasilh and Mental Hyglens. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show with injury or other traumatic event, the Medical Examiner must be notified at 605s.

Physician

/Medical

Examiner

Baitimore, Maryland 21215-0020

Physician/Medical Examiner attending physician and for use as the burial-transit Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed 25. Was case referred to medical examiner? Be 1 Yes 2 10 2 this 27. Manner of Death Certification: Natural Director: / 2 Accident 3∏ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completaly filled in edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

Registrar

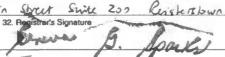
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Maria Street Suite

31. Days filed (Month, Day, Year)

20b. Signature and title of certifier

FEB 2 2 2000

Kaymond Milly mo



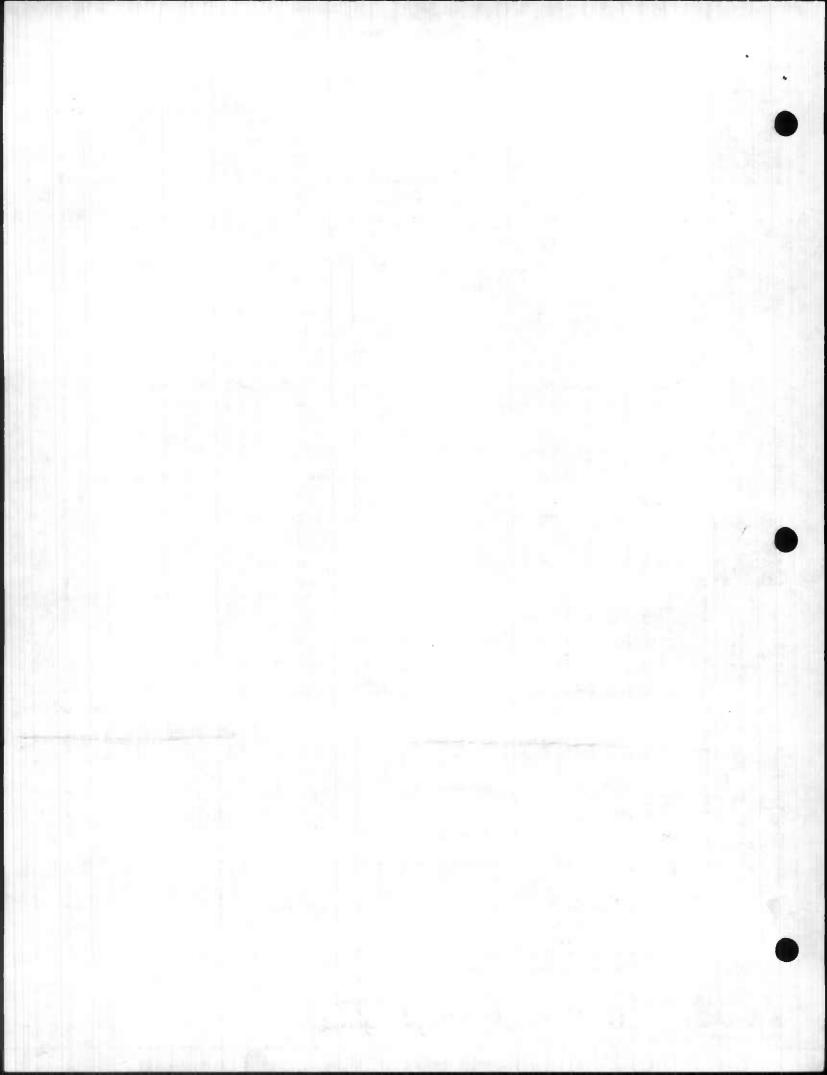
DHMH 16 Rev 6/95

29c. License number

D47683

29d. Date signed (Month, Day, Year)

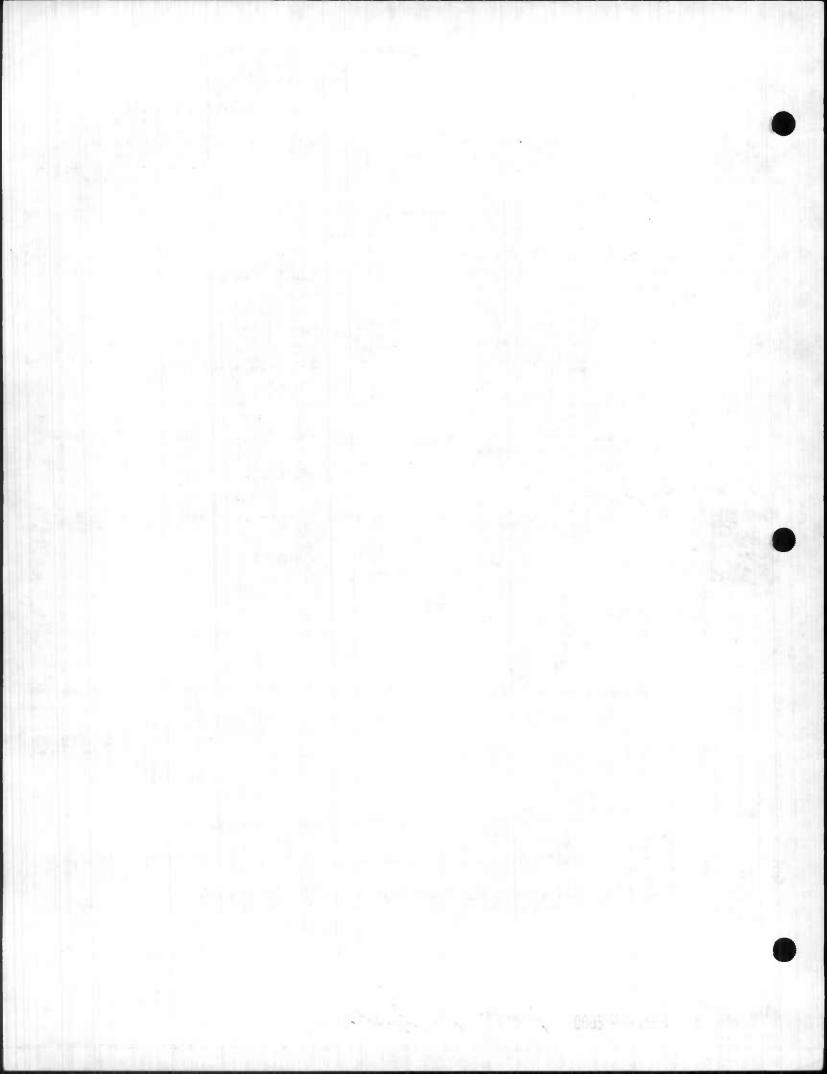
2/19/00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 3 8 0

| | | | | State of | iviaiyia | | tificate of | Death | viciliai riy | Reg. No. | 000 | |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------|-----------------------------------|------------------------------------|-----------------------------------------------------------|----------------------------------------------------|-----------------------------------------|-----------------------------------|-----------------------------------|-------------------------------------------------------|
| Я | Physician | 1. Decedent's Name (First, A | Aiddle, Las | 1) | | | | | 2. Date of De Month | Day | Year | Tima of Death |
| | /Medical Examiner | 4a Facility Name (If not insti | | street and num | iber) | | | 4b. City, Town, or I | ocation of Deat | 7 10 2 | of Death | 100 |
| di . | LAditiilet | University of | Max | yland 1 | redica | y Cent | W | Baltino | re City | Ba | lhmore | . CITY |
| | Funeral Director | 5. Social Security Number 148-38-1408 Usual Residence of Deceder | | x □M 2∏F | - 11 | s. last birthday) 95 Yrs. | ff Under 1 Year Months Days | | 8. Date of Bir (Month, Di JAN . 3 | th. Year) 1, 1905 | 9. Birthplace Country) | (State or Foreign POLAND |
| | pland M M | 10a. State 10b. Co | | | 10c. C | ity, Town or Lo | cation | | | | 10d. li | nside City Limits |
| | n the Marylar r 28a-f show Lostified at frector | N.Y. | QUEEN | IS | LI | TTLE N | ECK | | | | 1 | XYas 2□No |
| | # 2A D | 10e. Street and Number 54 - 40 LITT | CLE N | ECK PARI | KWAY | | 10f. Zip Code | 11362 | | 10g. Citizen of U.S. | | |
| 020 | natural, or thams 23/ disal Examinar must sted by Funeral | 11. Marital Status 1 Never Married 2 3 Widowed 4 Divo | a become | 12. Wes Deceder Armed For 1 Yes, Give Year or Da | ces? 2 🕱 No | | Wes Decedent of I f Yes, specify Cub 1 ☐ Yes 2 ☒ No | Hispanic Origin? (Span, Mexican, Puerl Specify: | pecify Yes or No o Rican, etc.) | | ck, White, etc. | dian, |
| 21215-0020 | within the hear he like | 15. Deci (Specify only h Elementary/Secondary (0- | | ucation de completed) College (1- | 4or 5+) | (Give | DO NOT use retire | during most of wor | king | | usiness/Industr | 1 |
| d 2 | STEE B | 17. Father's Name (First, Mic | idle, Last) | | | | | 18. Mother's Nam | ne (First, Middle | | | |
| ylar | Det o | SAMUEL | | HIRS | CH | SKLAF | RSH | RACHEL | | | (UNKNOW | (I) |
| , Maryland | and 2 sho salth and h n 27 is me er traume | 19a. Informant's Name/Relea | | | | | _ | GHTS AVEN | | | | |
| Baltimore, | Pages 1 nent of He ant: if Nen ury or oth | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Other | | | itete | cemetery, crea | sition (Name of natory or other pla CHAIM CEM | 1 | Date 2/20/00 | | ALE, MD | |
| Balt | Departi Departi Imports any inj | 21. Signature of Funisral Ser | vice Licens | 7 | | | Name and Address | ess of Facility STERSTOWN | | INSON & PIKESVI | | |
| | Dhysician physician and Medical Examiner the budal-transk article Examiner adical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ſ | eS | | (or as a consector as a consector) | | Camci | 28 | | Ons | set and Death |
| Box 68760, | | that initiated events resulting in death) Last | J | d | Due to (| or as a conseq | uence of): | | | | 1 | |
| P.O. | the d | Part II. Other significant con | ditions co | ntributing to dea | ath but not re | sulting in the u | nderlying cause gi | ven in Pert I. | 1200 | tobecco use co Yes 2□ No | ontribute to the | cause of death? |
| Records, | a been sign 2 should be pleted by | | | | | | | | | an autopsy ormed? | availab | utopsy tindings le prior to tion of cause h? |
| | The law ate has page 2 | | | | | | | | _ 10 | Yes 2 No | 1 🗆 Ye | s 2□ No |
| Vital | Physician: The this certificate ral director, pag. To Be Co. | 25. Was case referred to me examiner? | - | Hospital: | , | | _ 0 | 26. Place of Dea | | | | |
| ō | T G | 1 ☐ Yes 2 ☒ No 27. Manner of Death | | 28a. Date of | Injury | 28b. Time o | I SEL DON | 4 LI Nursing H | | how injury occur | | |
| ion | Attending For death. Setor: After by the funer Iffication: | E C PROGRAMM | restigation | (Month | , Day Year) | Injury | | ark?]Yes 2□No | | | | |
| Division | is or Attending P is after death. In Director: After the ed in by the funera Certification: | 3 Suicide 6 Co | ould not be termined | 28e. Place of building | of Injury - At I g, etc. (Spec | home, farm, str ify) | eet, factory, office | | | (Street and Numi wn, State) | ber or Rural Ro | ute Number, |
| | To the Hooptal or Attend within 24 hours after dest To the Funeral Director; completely filled in by the Medical Certificat | 29a. Certifier Cort (Check only ane) | ifying Phy Ical Exami | sician: To the bas and mann | sis of examin | owledge, deatl etion and/or in | occurred at the ti restigation, in my | me, date and place opinion, death occu | , and due to the rred at the time, | cause(s) and m date and place, | anner as stated and due to the | cause(s) |
| | withi within | 29b. Signature and title of ce | D.V | D /Kat) | Wall 1 | Byrd, M m k3a) (Type, | 29c. Licens | 10110 | | ebruar ed, Mo | | |
| | State Registrar | 31. Date filed (Month, Day, Y | • | | Himere. gistrar's Sign | | 21201 | Kativa | M. By | d, up | | |
| | ricgistiai | FEB 2 2 200 | JU | page 1 | 1 | 1. p.f. | arks | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| State of Maryland / Department of Health and N | Mental Hygiene | 05381 |
|------------------------------------------------|----------------|-------|
| Certificate of Death | Reg. No. | |

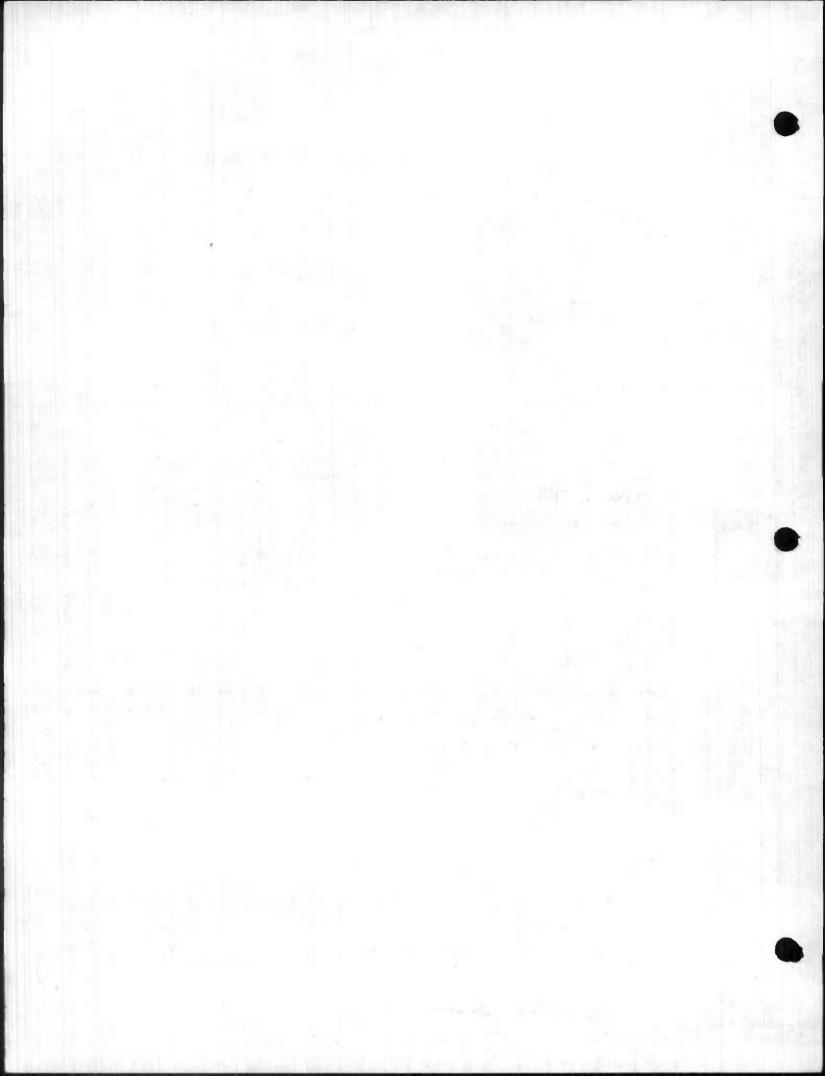
| | Certificate of Dea | ath Reg. No. | |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------|
| | Decedent's Name (First, Middla, Last) | 2. Dete of Deeth Month Day | 3. Time of Death |
| Physician /Medical | EDWARD L. CARTWRIGHT | FEB. 14 20 | |
| Examiner | 4e Facility Name (If not Institution, give street and number) 4b. City | ty, Town, or Location of Death 4c. Count | ty of Death |
| | | | /A |
| ral or | 229-30-2583 12M 2 F 70 Yrs. Months Days Hou | Indar 24 Hrs. 8. Date of Birth (Month Pay Year) 02/28/1929 | 9. Birthplace (State or Foreign Country) VIRGINIA |
| | Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location | | 10d. Inside City Limits |
| rector | MD N/A BALTIMORE | | 1 ☑ Yes 2 ☐ No |
| ect | 10e. Street and Number 10f. Zip Code | 10g. Citizen of | What Country? |
| Ö | 229 SOUTH BROADWAY 2123 | В1 П | SA |
| Funeral Director | | Ic Orlgin? (Specity Yas or No- | ice - Amarican Indien, |
| by Fu | 1 Naver Married 2 Married 1 XYes 2 No | ecity: Speci | ack, White, etc. |
| 2 | | 16b. Kind of I | Business/Industry |
| Be Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | nost of working | |
| COL | 12YRS. DISABLED | DISA | |
| | | Mother's Name (First, Middla, Maidan Suma | ima) |
| 2 | | ARGARET LEE | |
| | | Number or Rural Routa Number, City or Town | |
| | 20e. Method of Disposition 20b. Place of Disposition (Nama of | Date 20c. Location | - City or Town, Stata |
| any injury or other page. | 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) L.M.G. | 02/18/2000 CUR | |
| eny m | 21. Signature of Funeral Service Licensee 22. Name and Address of F HENRY W. J 4905 YORK | Facility JENKINS & SONS CO RD. BALTO., MD. 2 | 1212. |
| | 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line. | | Approximete Interval Between |
| an | | | Onsat and Death |
| al | Immediate Ceuse (Finel disease or condition a deute miscardial info | ection | mounte |
| iner | Immediate Ceuse (Finel disease or condition resulting in deeth) a. Quite Myocardial information pue to (or es e consequence of): b. Cotomany ating disease | ection | yeare |
| nine - | o Coronary aterry disease | | yeare |
| хап | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c. | | |
| edicai Examiner | cause. Enter Underlying Ceuse (Disease or injury that initiated events | | gene |
| | resulting in death) Last | | |
| M | a) Hypertension | | year |
| icia | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in f | Part i. 23b. Did tobacco use c | contribute to the cause of death? |
| hys | | | 3 Probably 4 Unknown |
| by F | LINOUSUUM CISCO | | |
| Completed by Physician/M | Chronic Bhygheine | 24e. Was an autopsy performed? | 24b. Wara autopsy findings sveileble prior to complation of cause of death? |
| o Be Comp | | 1□ Yes 2⊠No | 1 ☐ Yes 2 ☐ No |
| Be | 25. Was case referred to medical 26. | Place of Deeth (Check only ona) | |
| ToB | examiner? Hospital: Other | □ Nursing Home 5 ☐ Residence 6 □ 0 | ther (Specify) |
| | 27. Manner of Death 1 Natural 5 Pending 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. Injury 29c. | 28d. Describe how injury occ | |
| pletely filled in by the funera edical Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | 28f. Location (Street and Nur City or Town, State) | mber or Rural Routa Number, |
| completely filled in Medical Cert | 29a. Certifier (Check only 2 Msdical Examiner: On the bast of my knowledge, deeth occurred et the time, de | | |
| led led | one) and manner stated. | | |
| completely filled in by the Medical Certifical | 29b. Signature and title of certifier 29c. License num | nber 29d. Data sign | ned (Month, Day, Year) |
| | 1 Sperme 119, 000412 | 514 2/15/ | 2000 |
|) | 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) ALNOOR C. HERMANI M.D. 10 N. GREENE ST. | BALTO., MD. 2120 | 1. |
| State | 31. Date filed (Month, Day, Year) 32, Registrar's Signetura | | |
| gistrar | FEB 2 2 2000 Shows G. Soark | | |

G. Sparke

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death February 16 **Physician** Haskin Updegraff Deeley, Jr. 6:00 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 1 MM 2□ F Months Days 81 July 18, 1918 Washington, DC Director 213-14-3426 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Directo Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 434 Range Road United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: WW II 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Merried 2 Married 1□ Yes 2⊠ No Specify: Completed by 3 Nidowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Owner Dental Supply 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Pages 1 and 2 should be till ment of Health and Mental H tent; If feen 27 is merked off Haskin Updegraff Deeley, Sr. Lillian Justice 19e. informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura D. Chester (Daughter) 626 Debaugh Avenue Towson, Maryland 21204 20b. Place of Disposition (Name of cametery, cremetory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 2/18/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Fatte Leven T. 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In deeth) Last Due to (or es a consequence of) Box 68760, Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown trery disease Division of Vital Records, p 24b. Were autopsy findings available prior to Be Completed Strokes 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Deture or Attending after death. Director: Aft 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by th 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

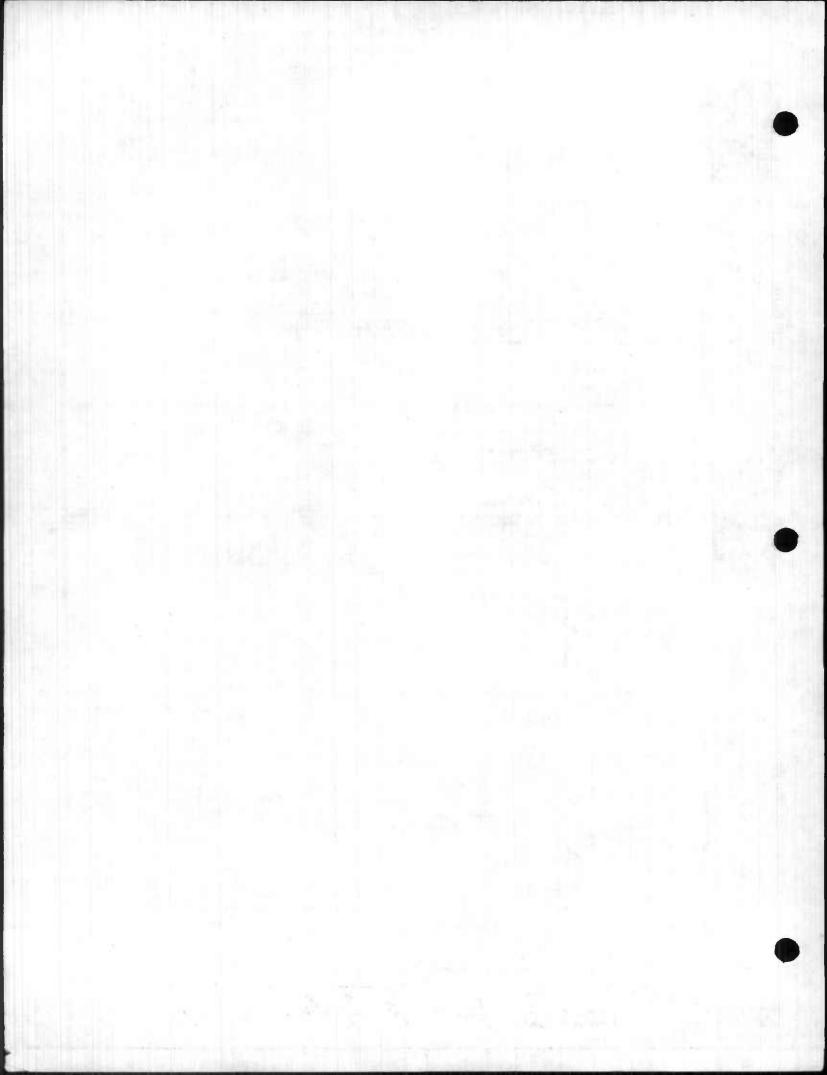
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and little of certify 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed space of deeth (Item 23a) (Type, Print) W. A. Riles N. Charles St. Bulto, md G-BMC 6701 32. Registrar's Signeture 31. Dete filed (Month, Dey, Year) State FEB 2 2 2000 Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\) \(\Ome

| | . Decedent's Name | e (First, Middle, L | ast) | | | | | 2. Date of De | Day V | 3. Time of Death | |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------|-------------------------------|------------------------------------------------------|--------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------|-----|
| ian cal | HELEI | NA LI | SA DAV | IS | | | | Februa | ary 15, 2 | 000 9:25 A.M. | |
| ner 4 | a Facility Name (II | f not institution, g | ive street and num | ber) | | | 4b. City, Town, or | Location of Deat | h 4c. County of | Death | |
| | Universi | ity of M | aryland N | Medica. | . Center | | Baltimor | e | N/Z | A | |
| | Social Security No. 214-86-41 Jesual Residence of | 314 | Sex 1□M XXF | | | Inder 1 Year nths Days | | | th iy. Year) 1970 | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Oa. State | 10b. County | | 10c. Ci | ty, Town or Location | n | | | | 10d. Inside City Limits | - |
| M is | ARYLAND | N/A | | | BALTIM | ORE CI | ITY | | | 1 ☐ Yes 2 ☐ No | |
| Director | 0e. Street and Nur | nber | | | 7 | f. Zip Code | | | 10g. Citizen of Wh | at Country? | |
| | 932 N I | DURHAM S | TREET | | | 2120 | 05 | | U.S.A | | |
| by Funeral | | ed 2 Married | 12. Was Deced Armed Ford 1 Yes If Yes, Give | ONKK | | | Hispanic Origin? (: ban, Mexican, Pue Specify: | Specify Yes or No to Rican, etc.) | 14. Race - Black, Specify: | American Indian, White, etc. | |
| D - | 3 Widowed | 15. Decedent's E | Year or Dat | les: | 16a Docadentis | Heural Occur | nation | | 16b. Kind of Busi | BLACK | _ |
| Completed | | ify only highest g | rade completed) | | (Give kind | of work done OT use retire | pation during most of wo ed) | orking | TOD. KING OF DUSI | riesariidustiy | |
| E | 10th gra | | College (1- | 4or 5+) | SECURI | TY SEI | RVICES | | PUBLIC | SAFETY | |
| 1 8 | 7. Father's Name (| | t) | | | | 18. Mother's Na | me (First, Middle | , Maiden Sumame) | | Ī |
| ToB | BENNIE I | DAVIS | | | | | MARGI | E L. BRO | OWN | | |
| | 19a. Informant's Na | me/Relationship | (Type, Print) | | 19b. Mailing Ad | dress (Stree | t and Number or F | lural Route Numb | er, City or Town, St | tate, Zip Code) | |
| | Margie I | Davis/Mo | ther | | 932 N. | Durhar | m Street, | Baltimo | ore, Mary | land 21205 | |
| 2 | On. Method of Disp | | | | Place of Disposition | (Name of | ace) | Date | 20c. Location - C | ity or Town, State | |
| | 1 t∆l48urial 2 L 4 □ Donation | ☐ Cremation 3 ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (Specification) ☐ Other (| ☐Removal from S | tate | KING MEMO | | | 2-22-0 | D RAI.TIMO | RE, MARYLAND | |
| 2 | 21. Signature of Fu | Miral Service Lies | Ging) | | 22. Nar | ne and Addr | ess of Facility | | | | - |
| | 1/1 | 1 Jugar | Decour | 0 | | | BROWN CO RTH AVENU | | FUNERAL | HOME PA | |
| | 23a, Parti Eranan | o disease, or cor | | | th. Do not enter the | | | | rrest, | Approximate Interval Between | + |
| cal Examiner | disease or condition resulting in death) Sequentially list confamp, leading to impause. Enter Under Cause (Disease or intainitiated events resulting in death) L. | nditions, mediate rlying injury | a. 30 (b. VS) (C | Due to (| or as a consequence or as a consequence or as a consequence | e of): | 00724.00 | (240.) | THERMO | | |
| clan/M | | L | d | | | | | | | | |
| Je P | art II. Other signifi | cant conditions | contributing to dea | ith but not res | ulting in the underly | ring cause gi | iven in Part t. | 1 | / | ribute to the cause of death? | |
| by Pl | | | | | | | | 163 | fes 2□No 3 | 3 Probably 4 Unknown | |
| Completed b | | | | | | | 4 | 24a. Was perfe | ormed? | 24b. Were autopsy lindings available prior to completion of cause of death? | |
| | E 1860 | and to co. 1.49 . 4 | | | | | | 10 | | 1 Dres 2 No | |
| 0 2 | 5. Was case referr examiner? | | Hospital: | | Iron | 7.00 | thor | eath (Check only | | 40 7.1 | |
| | 1 ☐ Yes 2 ☐ I 7. Manner of Death | | 28a. Date of | Injury | ER/Outpatient 3 | J DOA | 4 Li Nursing | 1 | dence 6 Other | | |
| tor | 1 Diáturel | 5 Pending investigation | (Month | , Day Year) | 12:42 PM | 28c. Inju Wo | ork? Yes 2 No | | | IN A HOUSE PIRE | 1 |
| 45 | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not l determined | 28e. Place o | of Injury - Ath g, etc. (Special AT 14 | ome, larm, street, f | | | City or To | wn, State) | or Aural Route Number, | - |
| Certification: | | | | | wledge death occ | rred at the t | ime, date and plac | e, and due to the | cause(s) and many | ner as stated. | |
| | 9a. Certifier (Check only | 1☐ Certifying P | miner: On the bas | is of examina | tion and/or investig | ation, in my | opinion, death occ | urred at the time. | date and place, an | d due to the cause(s) | 100 |
| ledical | (Check only one) | ZXMedical Exa | hysician: To the b miner: On the bas and manne | is of examina | tion and/or investig | ation, in my | | turred at the time, | date and place, an | d due to the cause(s) | - |
| Medical | (Check only one) | title of certifier | miner: On the bas and manne | sis of examine or stated. | ition and/or investig | ation, in my | opinion, death occurse number O.C.M.E. | surred at the time, | date and place, an 29d. Date signed (February | (Month, Day, Year) | |
| Medical | (Check only one) | title of certifier | miner: On the bas and manne | sis of examine or stated. | n 23a) (Type, Print) | 29c. Licen | o.C.M.E. | surred at the time, | date and place, an 29d. Date signed (| (Month, Day, Year) 16, 2000 | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 0 05384

Certificate of Death

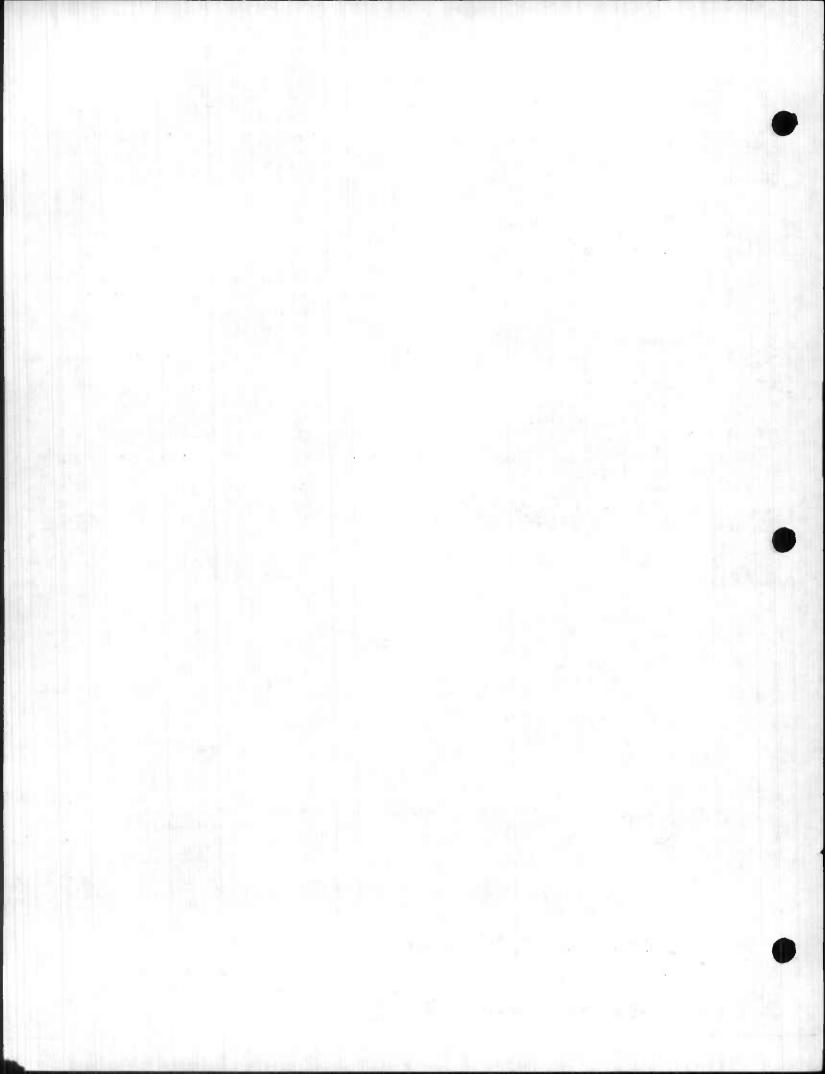
Reg. No.

2. Data of Death 3. Time of 0

| | | | | Cer | tificate | of E | eath | R | eg. No. | | |
|------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------|----------------------|---------------------------|----------------------------|--------------------------------|-------------------------------------------|----------------------------|------------------------------------|-------------------------------------------------------------------------|
| | 1. Decedent's Name (First, Middle | | | | | | | 2. Data of Dear | | Year | 3. Time of Deeth |
| sician | Emilie Sahlin | Dodge | | | | | | Februar | | 2000 | 11:30 pm |
| edical ıminer | 4a Facility Name (If not institution | give street and number | 91) | | | 4b | . City, Town, or L | ocation of Death | 4c. County | | TILL OU DIN |
| 1111101 | Sunrise Assist | ed Living o | of Annap | olis | | | Annapoli | .s | Anne | Arur | ndel |
| ral tor | 5. Social Security Number 214-38-0368 | 6. Sex 1 ☐ M 2 🔀 F | Age (In yrs. last 85 | birthday) _ Yrs. | If Under 1 Months | Year Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day May 20 | 1914 | | olaca (Stata or Foraign otry) Land |
| | Usual Residence of Decedent 10a. Stata 10b. County | | 10c. City, To | own or Loc | ation | | | | | 1 | 0d. Inside City Limits |
| / Funeral Director | MD Anne | Arundel | Annap | olie | | | | | | | 1 Yes 2 No |
| 9 | 10e. Street and Number | ALUMGEL | Aimar | OIIS | 10f. Zip C | Code | | 1 | Og. Citizen of | What Cour | ntry? |
| a D | 984 Sherwood F | orest Road | | | 2: | 1401 | | | US | A | |
| Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | 12. Was Decede Armed Force ed 1 Yes 2 If Yas, Give Year or Date | s? XINo | H | /as Decede Yes, specif | y Cuban | , Mexican, Puerto | pecify Yes or No- Pican, etc.) | | ce - Amaric ck, White, y: Wh | |
| mpleted | 15. Decedent (Specify only highest Elementary/Secondary (0-12) | grade completed) College (1-4c | or 5+) | (Give k | O NOT use | done du | tion uring most of work | king | 16b. Kind of B | | dustry |
| S | 17. Father's Name (First, Middle, L | 5+ | 1 | each | er | | 18 Mother's New | ne (First, Middle, I | Educa | | |
| To Be Comp | Nils Sahlin | and i | | | | | | tha Lanc | | rra) | |
| To | 19a. Informent's Name/Relationsh | in (Type Print) | 1 | 9h Meiling | Address / | Street e | | ral Route Number | | State Zin | (Code) |
| | Charles Dodge | | | | | | | Road, Ann | | | |
| | 20a. Method of Disposition | | 20b. Place | of Dispos | ition (Name | of place | 1- | | 20c. Location | - City or To | wn, Slata |
| | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | | | t Ceme | | Y iC | 2000 | Annapo | lis. | Maryland |
| any injury DOGS. | 21. Signature of Funeral Service L | P. Full | sed the death. D | | 12 Ric | sty dgel | Funeral y Avenue | Home, P. Annapo or respiretory err | olis, M | D 214 | Approximate Interval Between Onset and Death |
| ian cal ner | Immediate Causa (Final disease or condition resulting in death) | a | myc | 051 | 2 | Fu | ngo | ides | | 1 1 | years |
| ě | | | Due to (or as | a consequ | uence of): | | | | | | / |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | ь | Due to (or as | a consequ | ience of): | | | 13 | | 4 | |
| a as the bunal-transit Medical Examir | Cause (Disease or Injury that initiated events resulting in death) Last | c | Dua to (or as | a consequ | ence of): | | | - 4 | | | |
| clan | | d | | | | | | | | I | |
| by Physician/ | Part II. Other significant condition ad vance of | demen | | , | derlying car | | | 23b. Did to | V | 3 Pro | the cause of death? |
| pleted | | | | | | | | 24a. Wes a perform | n autopsy med? | av co | ere autopsy findings altable prior to mpletion of cause death? |
| rector, page 2 | | | | | | | | 1 🗆 Y | es 20 No | 10 | ☐ Yas 2☐ No |
| lo Be | 25. Was casa referred to medical axaminar? | | | | | | 26. Place of Dee | th (Check only or | 19) | | Accieb |
| | 1 ☐ Yes 2 No | Hospital: 1 ☐ Inpa | - | Outpatient | | | 4 U Nursing H | ome 5 Reside | ence BOOt | ner (Specif | y) / July |
| Certification: | 27. Menner of Death Natural 5 Pending Investign | | Day Year) 28 | o. Time of Injury | M 28 | c. Injury Work 1 Y | at ? es 2 □ No | 28d. Describe h | ow injury occu- | rred | Facility |
| d in by a | 3 Suicide 6 Could no determine | ned 200. Place of | Injury - At home, etc. (Specify) | farm, stre | et, factory, | office | | 28f. Location (Si City or Town | treet end Num n, Stata) | ber or Rure | al Route Number, |
| completely filled in by the Medical Certifical | | Physician: To the best xaminer: On the basis and manner | of examination | | | | | | | | |
| M Me | 29b. Signature and title of certifier | | _ | | 29c. | License | nu <i>m</i> ber | 2 | 9d. Data signe | d (Month, | Day, Year) |
| | mas | 200 | - | - | 7 | D | 4195 | 5 | 2. | 21- | 00) |
| 0 1 | 30. Name and address of person w | ho completed cause of | death (Item 23 | a) (Type, P | Print) | 0. 6 | HOP F | 1 #304 | 1 50 | ver | na Park |

State Registrar 31. Date filed (Month Day, Year)
FEB 2 2 2000

32. Registrar'a Signature

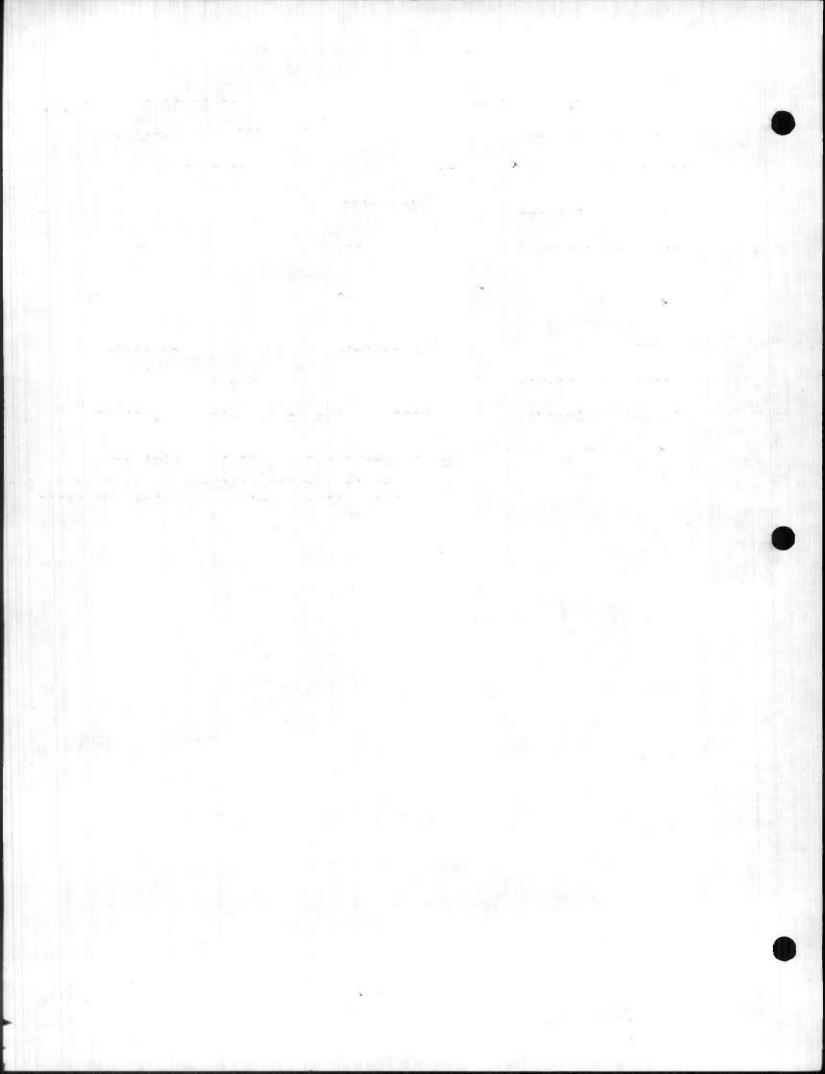


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State of Maryland / Department of Health and Mental Hygiene 0 0 5 3 8 5

| | | | Ce | ertificate of | Death | 8 | leg. No. | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------|-------------------------------------------|---------------------------------------------|--------------------------------------|---------------------------------|------------------------------------------------------------------|
| | 1. Decedent's Nama (First, Middla, | Last) | | | | 2. Data of Dea Month | | Year | 3. Tima of Death |
| Physician /Medical | Betty S. | Denikos | | | | 02 17 | | rear | 7a.m. |
| Examiner | 4a Facility Name (II not institution, g | rive street and number) | | | 4b. City, Town, or | | 4c. County of | of Death | |
| | 7325 New Cut | Road | | | Kingsvi | ille | Balti | more | |
| Funeral Director | 5. Social Security Number 2 16 - 2 4 - 5 7 6 7 | 1□M 2MF | rs. last birthday | Months Days | | (Month, Day | Year) 1929 | 9. Birthpla Country P | ce (Stata or Foreig A) |
| 2 . | Usual Rasidanca of Decedant | 100 | Oh. Your oak | | | | | | |
| a Maryla a-f show tifled.at ctor | Md Balti | | City, Town or I | gsville | | | | 100 | I. Inside City Limi 1 ☐ Yas 2 R N |
| th with the Ma 23a or 28a-f s at he notified al Director | 10e. Street and Number 7325 New Cut | Road | | 10f. Zip Code 2 1 0 8 | 7 | 1 | 0g. Citizen of W USA | | n |
| ours after death of the standard must be Examiner must by Furneral | 11. Marital Status 1 Nevar Married 2 Married 3 K Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: | n U,S. 13 | Was Decedent of If Yas, specify Cul | | Specify Yas or No- to Rican, atc.) | | - American c, Whita, at | c. |
| d 2 should be filled within 72 hours at the archael Hygierie. This marked other than "natural", or treumetic event, the Medical Example To Be Completed by F | 15. Decedent's (Specify only highast (| rada completed) | 16a. Dec (Giv lifa. | edent's Usual Occura kind of work done DO NOT use retin | pation during most of wo | rking | 16b. Kind of Bus | siness/Indu | stry |
| the plant | Elementary/Secondary (0-12) | Collega (1-4or 5+) | Веа | autician | | | Cosmet | olog | У |
| to the same of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of | 17. Fathar's Nama (First, Middla, La | st) | | | 18. Mother's Na | me (First, Middle, | Maiden Sumame | 9) | • |
| o seed o | William Vasil | akis | | | Eva | Verge | | | |
| WANTED TO | 19a. Informant's Name/Ralationship | (Type, Print) | 19b. Mai | iling Addrass (Stree | t and Number or R | ural Route Number | r. City or Town. S | Stata, Zio C | (ode) |
| tra a se | Michael Deniko | | | New Cu | | | | | |
| Hand State | 20a. Mathod ot Disposition | 200 | b. Place of Disp | position (Nama of | ! | Data | 20c. Location - 0 | City or Tow | n, Stata |
| 0 m 0 | 1 ⊠ Burial 2 ☐ Cremation 3 | | | amatory or other pl | | | | | |
| G state | 4 Donation 5 Other (Special | | | rothdox | | 02 19 | Baltim | ore, | Md |
| ado de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguina de la seguin | 21. Signatura of Funaral Service Lic | ensee | F | 22. Nama and Addr 3radley- | ess of Facility Ashton = | Matthew | s Fune | ral | Home. |
| permit. Pages 1 at Department of Hee Important: If Item any injury or othe once. | | | | 2134 Wil | | | | | |
| ate be executed thysician end the buriel-transit dical Examiner | Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated avants | b. LEIONY Dua to | o (or as a cons | ROMA | | ACH | | 1 | |
| 5 9 2 | that initiated avants resulting in death) Last | | o (or as a conse | | | | | | |
| ss that the death certing gned by the attending be detached for use a by Physician/M | Part II. Other significant conditions | contributing to death but not | rasulting in tha | undarlying causa g | iven in Part I. | | | tribute to t | he cause of deat |
| that i that i hed i e det | | | | | | , | 2010 | 0_11000 | ory 4 Domina |
| been si should | | <u> </u> | | | | 24a. Was a perfor | n autopsy med? | 24b. Wara avail comported | a autopsy findings able prior to pletion of cause sath? |
| The la | | | | | | 1 D Y | as 2 No | | Yas 2□ No |
| ysician: The lav is certificate has director, page 2 To Be Comp | 25. Was casa rafarred to medical | | | | | | N. Contract | | 185 Z 140 |
| certifican rector | axaminar? | Hospital: | | | her: | ath (Check only or | | | |
| Physician: this certific ral director, TO Be | 1 Yas 2 No | 1 L Inpatient 2 | | BUIL 3FT DOV | 4LI Nursing i | Homa 5 DAAasid | | | |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | 1 □Natural 5 □ Pending 2 □ Accidant invastigat 3 □ Suicida 6 □ Could not | be on Dissertation A | | M 1 | Yas 2 No | 28d. Describe h | | | Bouto Mumbos |
| tel or Al | 4 Homicide detarmine | 28a. Placa of Injury - A building, atc. (Spe | ecify) | meat, ractory, office | | City or Town | | o nutel l | Toda Humber, |
| To the Hospital within 24 hours To the Funeral completely filled | 29a. Cartifier 1 Certifying F (Check only one) 2 Medical Ex | Physician: To the best of my imminer: On the basis of axam and mannar stated. | knowledge, das ination and/or l | th occurred at tha t nvastigation, in my | ima, data and place opinion, daath occ | a, and dua to the c urred at the time, d | ause(s) and mar late and place, a | nner as stai | led. he cause(s) |
| Nethir Me | 29b. Signatura and titla of certifier | | | 29c. Lican | se number | 2 | 9d. Date signed | (Month, Di | ay, Year) |
| - > L. O | > Saba Si | ddie: n | 20 | DI | 1496 | | 2-1 | 7-7 | (تداوی |
| \ | | 10 | | | | | | _ | |
| d | 30. Name and address of person where \$ABA-\$1 | | | Temme Jork | ers r | ZUN RO | AD B | MALTO | am c |
| State Registrar | FEB 2 2 20 | 32. Registrar's Sig | gnatura | poore | V | | | | 24 |

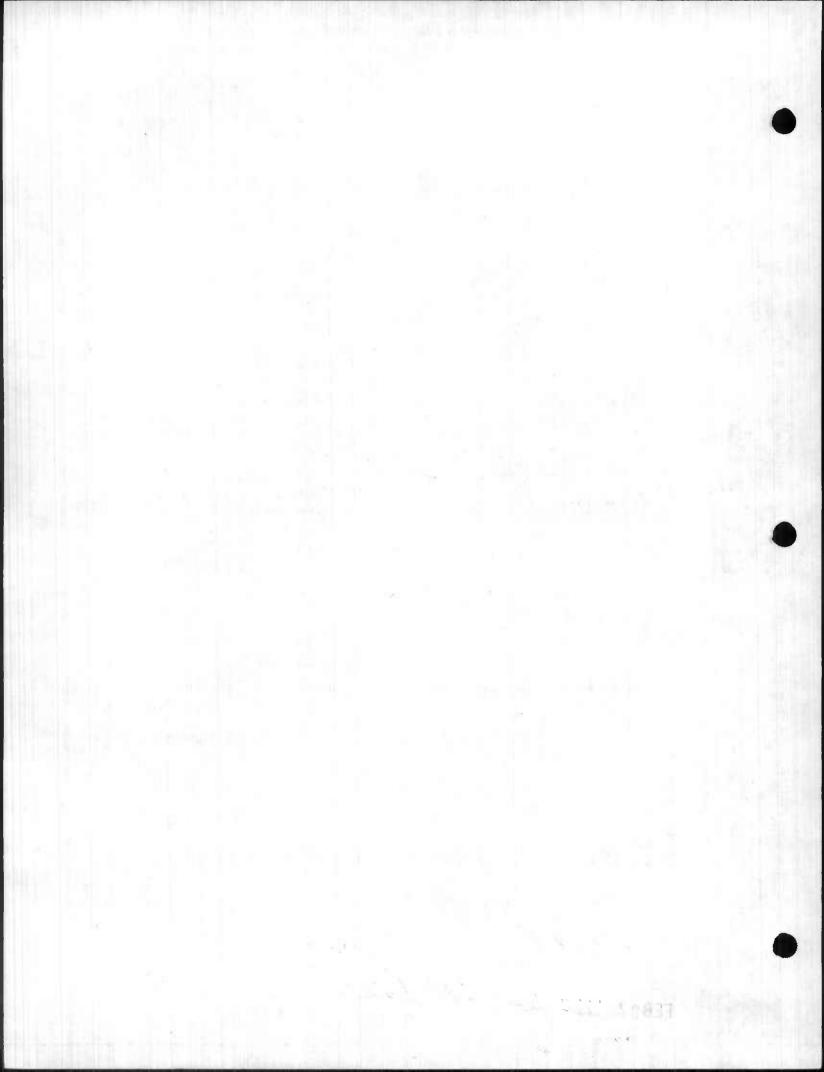
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| | | | Cer | tificate of | Death | F | leg. No. | 03300 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------|------------------------------------------|---------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 1. Decedent's Name (First, Middle, Las | () | | | | 2. Date of Dea | th | 3. Tima of Death |
| Physician (Madical | Clara C. Dixon | | | | | February | 20, 20 | 00 6:00AM |
| /Medical Examiner | 4a Facility Name (If not institution, give | street and number) | | | 4b. City, Town, or | Location of Death | 4c. County of | |
| Zxammer | Morning Side House | e at Satyr H: | i 1 1 | | Baltimor | е | Baltim | nore |
| Funeral Director | 5. Social Security Number 6. Se | | rs. last birthday) Yrs. | Months Days | | | Year) | 9. Birthplace (State or Foreign Country) Maryland |
| 20 | Usual Residence of Decedent | | | | | | | |
| e Maryland le-f show diffed at ctor | MD Baltimor | | City. Town or Lo | | | | | 10d. fnside City Limits 1 ☐ Yes 2 No |
| or 28e-1 s be notified Director | 10e. Street and Number | | | 10f. Zip Code | | | Og. Citizen of W | hat Country? |
| 23a o sust be rel Di | 8800 Old Harford | | | 21234 | | | | States |
| 72 hours after death with the Marylar natural, or listne 23e or 28e-1 show sleaf Examiner most be notified at sted by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | | Vas Decedent of Yes, specify Cut □ Yes 2 No | | Specify Yes or No- to Rican, etc.) | Black | - American Indian, c, White, etc. White |
| ad within 72 ho ygiene. ner than "naturi 4, the Medical. | 15. Decedent's Edu (Specify only highest grad | | 16a. Deced | lent's Usual Occu | pation during most of wo | orking | 16b. Kind of Bur | ainess/induatry |
| of 2 should be filed within 72 hours at the and Mental Hygiene. It is marked other than "natural", or treamatic event, the Medical Exam. To Be Completed by F | Elementary/Secondary (0-12) | College (1-4or 5+) | | maker | , | | Own Ho | ome |
| tal Hy d othe event, Be C | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | me (First, Middle, | Maiden Sumame | 9) |
| Menta fice fice | William Harry Sa | uter | | | Catheri | ne Migan | | |
| 2 sho and is ma nume | 19a. Informant's Name/Relationship (T) | | | | | ural Route Numbe | | A CONTRACTOR OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY O |
| | Mrs. Anne J. Peksa/Nied | | | | ay, Dags | bora, Del | | 19939 |
| semit. Pages 1 a. Department of Hea reportant: If Hear, my Injury or other BDGB. | 20a, Method of Disposition 1 A Burial 2 Cremation 3 4 Donation 5 Other (Specify) | Removal from State | | sition (Name of natory or other pla ledeemen Ca | | Date 02/23/00 E | | City or Town, State Maryland |
| permit Depart Import any inj ance. | 21. Signature of Funeral Service Licens | Christina L. | David | Name and Addr 305 Harford | L | eonard J. I timore, Man | | |
| Physician | 23a. Part1. Enter the disease, or comp ahock, or heart failure. List only of | | | | | c or respiratory are | rest, | Approximate finterval Between Onset and Death |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | b. ROITTC S | P Gr | art Fu | ilure | | | lyear |
| je je | | Man (Fir C | Lm (1) | uence or). | | | | lance- |
| outed ransi | Sequentially list conditions. | b. Due to | (or as a conseq | uence of): | | | | 19491 |
| e axe ilan a uriaH uriaH | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | |
| tificate be axecuted g physician and as the burial-fransit | Cause (Diseese or Injury that initiated events resulting in death) Last | Due to | (or as a consequ | uence of): | | | | |
| certificate be axiding physician use as the burial | | d | | | | | | 1 |
| atter for L | | | | | | 1 | | |
| es that the death certinged by the attending be detached for use a by Physician/M | Part II. Other algorificant conditions con | | esulting in the ur | nderlying cause gi | ven in Part I. | 23b. Did to | 1 | tribute to the cause of death? 3 Probably 4 Unknown |
| The law requires that the death certificate be assocuted to has been signed by the attending physician and page 2 should be detached for use as the burist-transit completed by Physician/Medical Examin | | | | | | 24a. Wes a | | 24b. Were autopsy findings available prior to completion of cause |
| The law require sate has been single page 2 should Completed | | | | | | 101 | ea 20 No | of death? |
| or, p | 25. Was case referred to medical | | | | 26 Place of Do | ath (Check only or | | 12100 2410 |
| hysicien: his certific director | axaminar? | Hospital: 1 ☐ Inpatient 2 | ☐ ER/Outpatien | OI DOA | | | | or (Specify)Assisted '_i\ |
| ther this uneral on: T | 27. Manner of Death Netural 5 Pending | 28a. Date of injury (Month, Day Year) | 28b. Tima of | 28c. Inju | ry at | Y | ow Injury occurre | 11/11/07 |
| To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. Place of fnjury - At building, etc. (Spe | home, farm, atre cify) | | Yes 2 No | 28f. Location (S City or Tow | itreet and Numbe n, Stete) | er or Rural Route Number, |
| To the Hospital of within 24 hours a Within 24 hours a To the Funeral D completely filled i Celling Medical Celling in the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Com | 29e. Certifier (Check only one) Certifying Phy. 2 Medical Exami | afcian: To the best of my k ner: On the basis of exami and manner stated. | nowledge, death netion and/or inv | occurred at the trestigetion, in my | ma, date and place opinion, deeth occ | e, and due to the c urred at the time, c | ause(s) and mar late end pleca, a | nnar as atated. and due to the cause(s) |
| Vithin Complex | 29b. Signature and title of certifier | | | 29c. Licen | se number | 2 | 9d. Date signed | (Month, Day, Year) |
| 11/ | 1 Tours | Came u | | 72 | 0673 | | 2-21-0 | 00 |
| COS | 30. Name and address of person who co | empleted cause of death (It | em 23a) (Type, I | 1 10// | Adr. | I work, | MD 21 | 236 |
| State | 31. Date filed (Month, Dey, Year) FFR 9 2. 2000 | he 33 Bagistrar's St | | uls | 1.401 | 1 | | |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Dete of Deeth FEBRUARY D 19, 2000 6:34 AL **Physician** DOLPHUS JACK DAVIS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 309 OXFORD DRIVE GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) JUNE 20, 1933 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours WEST VIRGINIA Yes 236-48-7794 66 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits show MARYLAND ANNE ARUNDEL MILLERSVILLE 1 ☐ Yes 2 No Director notifie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? na 23a or 8049 VETERANS HIGHWAY, #70 ROL-PARK 21108 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 53-5 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, atc.) Mama 14. Rece - American Indian, Bleck, White, etc. hours after 1 Never Married 2 Merried b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced 53-57 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 interest of Health and Mental Hygiene.
sett: If lesm 27 is marked other than "nation or other traumatic event, the Medica Elementary/Secondary (0-12) College (1-4or 5+) PIPE FITTER STEEL MAKING 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 88 CLARA ETHEL COCHRAN WARDEN DEE DAVIS 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVA TURNER / SISTER 309 OXFORD DRIVE, GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete FEB. 23 20c. Location - City or Town, Stete 1 Burial 2 Campation 3 Parmoval from State Department of Important: If any injury or once. CROWNSVILLE, MARYLAND CROWNSVILLE MD VET. CEM. tion (Other (Specify) 2000 21. Signatura of Foreign Service Lie 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD Ness, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, that only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed **burial-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and a consequence of) Box 68760, physician Physician/Medical the Dua to (or as e consequence of): 88 080 Po 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o 1 Yes 2 No 3 Probably 4 Winknown 0 of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has page 2 200 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: director. 25. Was case referred to medical examiner?
1 ⚠ Yes 2 ☐ No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOME Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 1 2 Netural 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? After 5 Pending investigation Division after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D edicai 29s. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

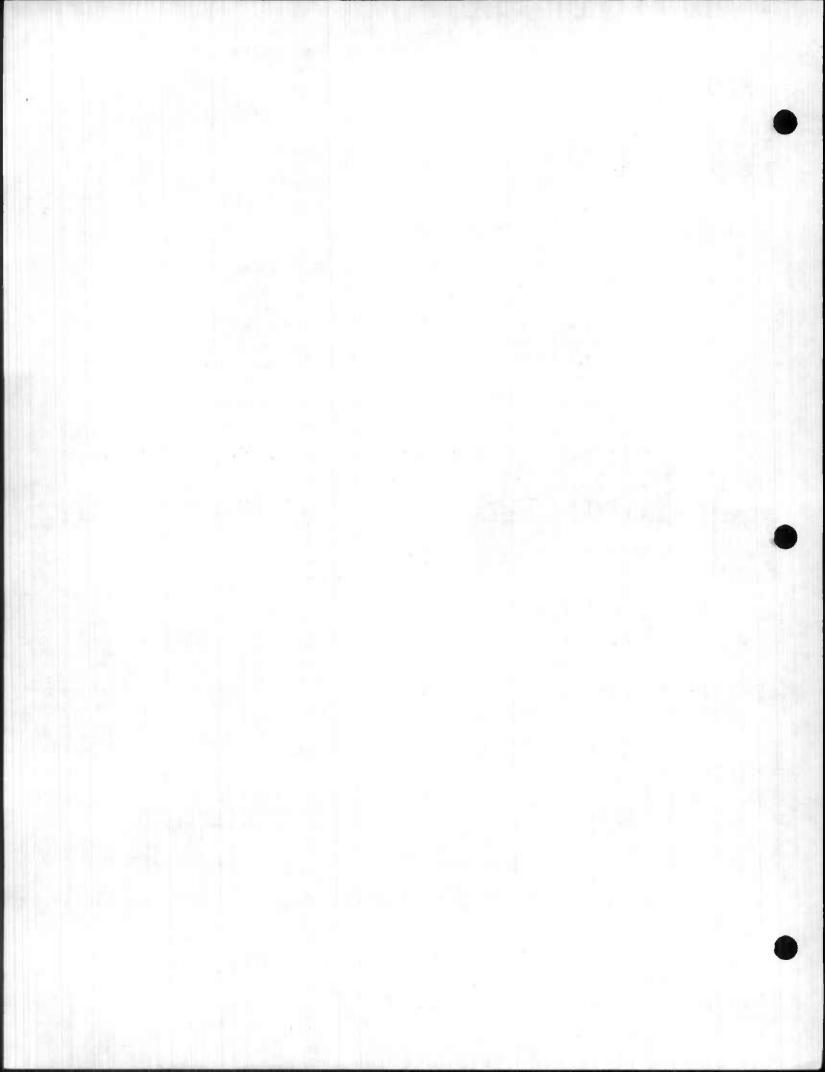
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D28640 FEBRUARY 20, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY BRIGGS, M.D., P.O. BOX 28, CROWNSVILLE, MARYLAND 21032 31. Date filed (Month, 15) Pen 2 - 2 200 32. Registrar Signature

DHMH 16 Rev 6/95

State

Registrar

Darks.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death Day Month Year February SHARON FUTRILL В. 2:45AM 2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore 8. Data of Birth (Month, Day, Year) DEC 7, 194 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Months Days Hours 1□M 2□F BALTI ORE MD 52 218-76-5761 Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No MARYLAND BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3727 BELLE AVE. 21215 USA 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yes 2 No 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: AFRO AMERICAN 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltega (1-4or 5+) HOME! AKER HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) UNKNOWN UNKNOWN 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) WYATT 3727 BELLE AVE, BALTIMORE, MARYLAND 21215 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) GARRISON FOREST V.A. CEM 2/24/00 OWINGS MILL, MD. 21. Signature of Funaral Service Licensee ESTEP BROTHERS FUNERALSER, P A. EUTAW PLACE, BALTIMORE, MD. 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Finat . Gastrointestinal 2 days diseasa or condition rasulting in death) Sequentially list conditions, if eny, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated eventa rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Breast Cancer tastatic 24b. Wara autopay findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 3 No 1 Yas 25. Was casa ratarred to medical examinar? 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1. Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifian 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

Examiner Division of Vital Records, P.O. Box 68760

i or Attanding Physician: after death. Director: After this certific 24 hours a Hospital

Physician/Medical

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31. Date filed (Month, Day, Year) FEB 22

29b. Signature and title of certifie,

Sinai Hospital of Baltimore 2401 West Belvedere Avenue, Baltimore Maryland 21215 32. Registrar's Signature

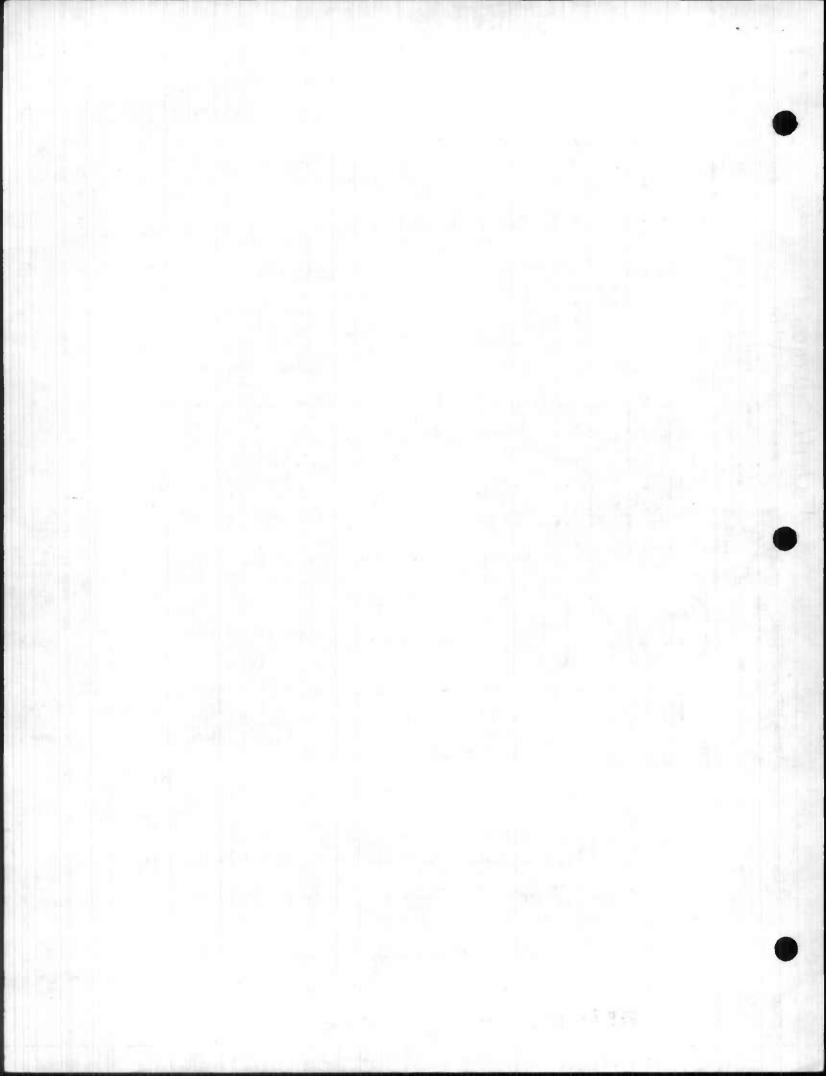
tank MD, Resident Physician

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

books

29c. Licensa number

29d. Data signed (Month, Day, Year)



State Registrar

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Karen Babrett, M.D.

Karen Babitt,

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2401 W. BeIVEdere Avenue, Baltimore, MD 21215

February 17, 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Josephine E. Fertitta 1820 4b. City, Town, or Location of Deeth 4c. County of Deeth 4s Facility Nama (If not institution, give street and number) _C.Fy Baltmore Tinai Hospital of Baltimore City If Under 1 Yeer If Under 24 Hrs. B. Dete of Birth
Months Deys Hours Min. Nov. 25, 1915 Mary Land 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 1 M 2 XF 84 Months 220-22-1443 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 157 Wilgate Rd. 21117 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Rece - American Indien, Bleck, Whita, etc. 11. Meritel Stetus 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Yeer or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Assembly worker Bendix 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Joseph John Fertitta Rose Steriale 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Frances Nunn - Niece 157 Wilgate Rd., Owings Mills, Md. 21117 20e. Method of Disposition 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete Druid Ridge Cem. Feb. 23,2000 Pikesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility Eckhardt Funeral Chapel sease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, ure. List only one cause on each line. Owings Mills, Md. Approximate Interval Between Onset end Death tmmediete Cause (Final cerebrovascular accid a Henorhagic diseese or condition resulting in deeth) Due to (or as e consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide TS Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner steted. 29a. Certifier (Check only one)

Examiner physician and the bunat-transit certificate be asscuted Box 68760, 080 P.O. signed by the a Records, peen s page 2 certificata Division of Vital or Attending Physician: this After thi funeral death. Director: / within 24 hours after de To the Funeral Directo completely filled in by th To the Hospital o within 24 hours at To the Funeral D

Examiner Physician/Medical by Completed Be Certification: To Medical

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Physician /Medical

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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State Registrar

2 MD Name and address of p

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29b. Signature and title of partific

31. Dete filed (Month, Day, Year)

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Be vedere Ave

29c. License number

29d. Dete signed (Month, Day, Year)

Tho completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** EUGENE FEB. 20 2000 FIELDS 2:30am /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 07/15/1958 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Davs Hours Months 1 M 2 □ F 216-74-5467 41 MARYLAND Director **Usual Residence of Decedent** 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1⊠ Yas 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 1522 HOMESTEAD ST. 21218 "natural", or thems 23a USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECURITY CO. 10 YRS SECURITY REPRESENTATIVE parmit. Pages 1 and 2 should be fit. Department of Health and Mental Hy. Important: if hen 27 is marked on any injury or other. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be HENRY FIELDS MARION BATTLE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEZA R. FIELDS(WIFE) 1522 HOMESTEAD ST. BALTO., MD. 21218. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 02/24/2000 PARKVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last therosclerosis Box 68760 Physician/Medical Due to (or as a consequence of) USB P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yaa 2 | No 3 | Probably 4 Vunknown Division of Vital Records, b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? After 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier niner: On the busin of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and marying stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2-20-2000 03802 in NO 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print)

Registrar **DHMH 16 Rav 6/95**

State

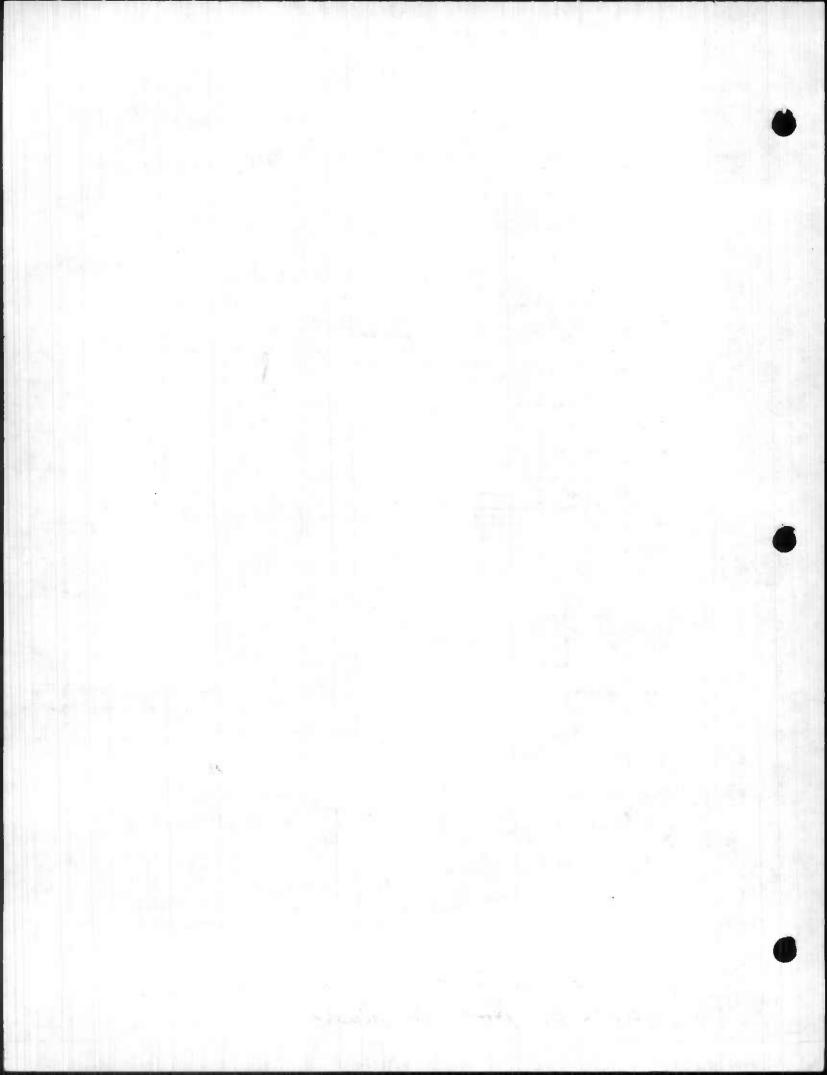
201

32. Registrar's Signature

MARK KING M.D. 31. Date filed (Month, Day, Year)

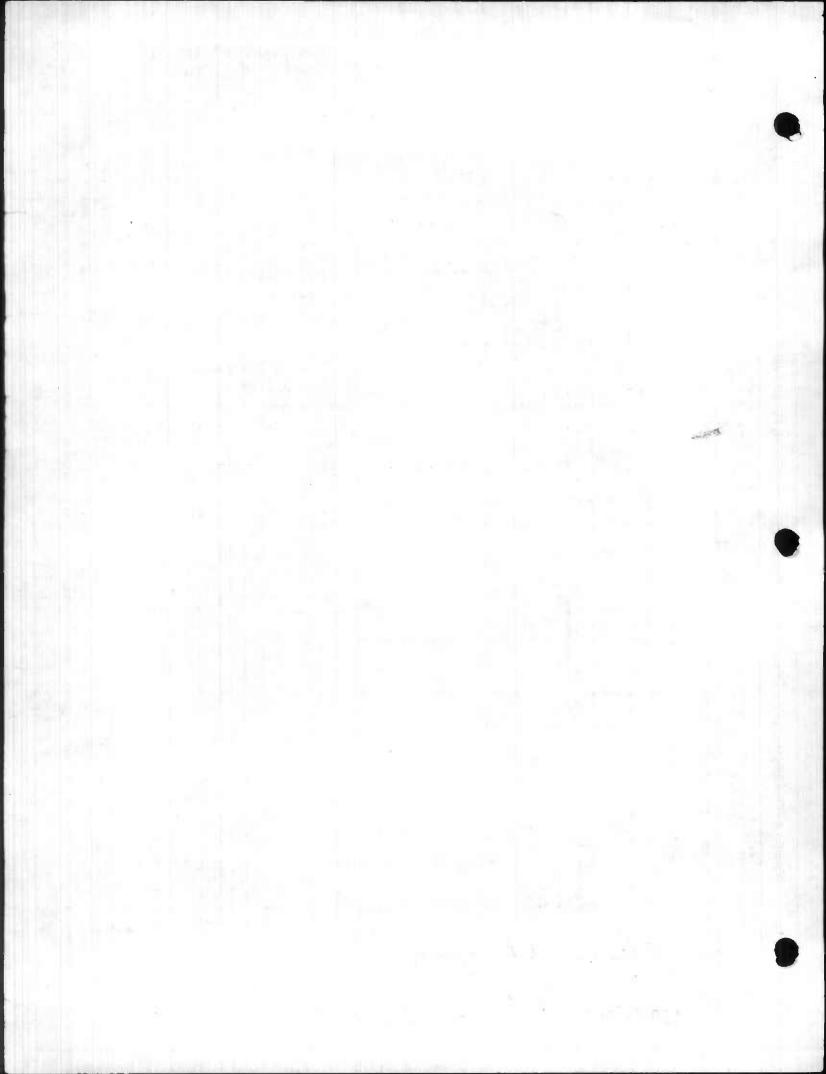
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EAST UNIVERSITY PARKWAY BALTO., MD. 21218.



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day John Charles Finzi Feb. 18, 2000 9:00 pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11445 High Hay Drive Columbia If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 12 M 2□ F Months Hours 560-26-7653 Yrs. 79 Mar. 27, 1920 Italy Usual Residence of Decedent 10h Counh 10c. City, Town or Location 10d. Inside City Limits Howard Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11445 High Hay Drive 21044 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1⊠ Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress Executive Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gina Pirani Otello Finzi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 11445 High Hay Drive, Columbia, Md. 21044 Paul Lorentzen, Pers. Rep. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore/Washing. Crem. 2/21/2000 Laurel, Md.

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

5555 Twin Knolls Rd., Columbia, Md.

Pages 1 and 2 ahould be filed within 72 hours after to that of health and Mental Hygiene. Intil Nem 27 is merked other than "netural", or les iny or other traumatic event, the Medical Examinative p Completed Be

Physician

/Medical

Examiner

10e State

MD.

Director

Funeral

Funeral

Director

28a-f

na 23a or

with the Maryland

Maryland 21215-0020

Baltimore,

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physicien:

Hospital

After this

Box 68760,

of Vital Records, P.O.

Division

Department of important: If any injury or

attending physicien end for use as the burial-transit signed by the a þ Completed funerai a 24 hours after death.

• Funeral Director: After the furnished in by the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the furnished in the

Physician/Medical Examiner

Certification: To Be 27. Manner of Death

Medical

State

Registrar

completely

within 2 9

Handa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 ☐ Yes 2 ☐ No

1 Natural

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

21. Signature of Funeral Service Licensee

Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal insufficiency 25. Was case referred to medical examiner?

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

5 Pending investigation 6 Could not be determined

Lemmer

Cardiomyopathy

Due to (or as a consequence of):

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

24a. Was en eutopsy performed?

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number D15043 29d. Date signed (Month, Day, Year) 00

23b. Did tobacco use contribute to the cause of death?

1 Yea 2 No 3 Probably 4 Unknown

21045

years

Approximate Interval Between Onset and Death

several

24b. Were autopsy tindings available prior to completion of cause of death?

t ☐ Yes 2 ☐ No

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

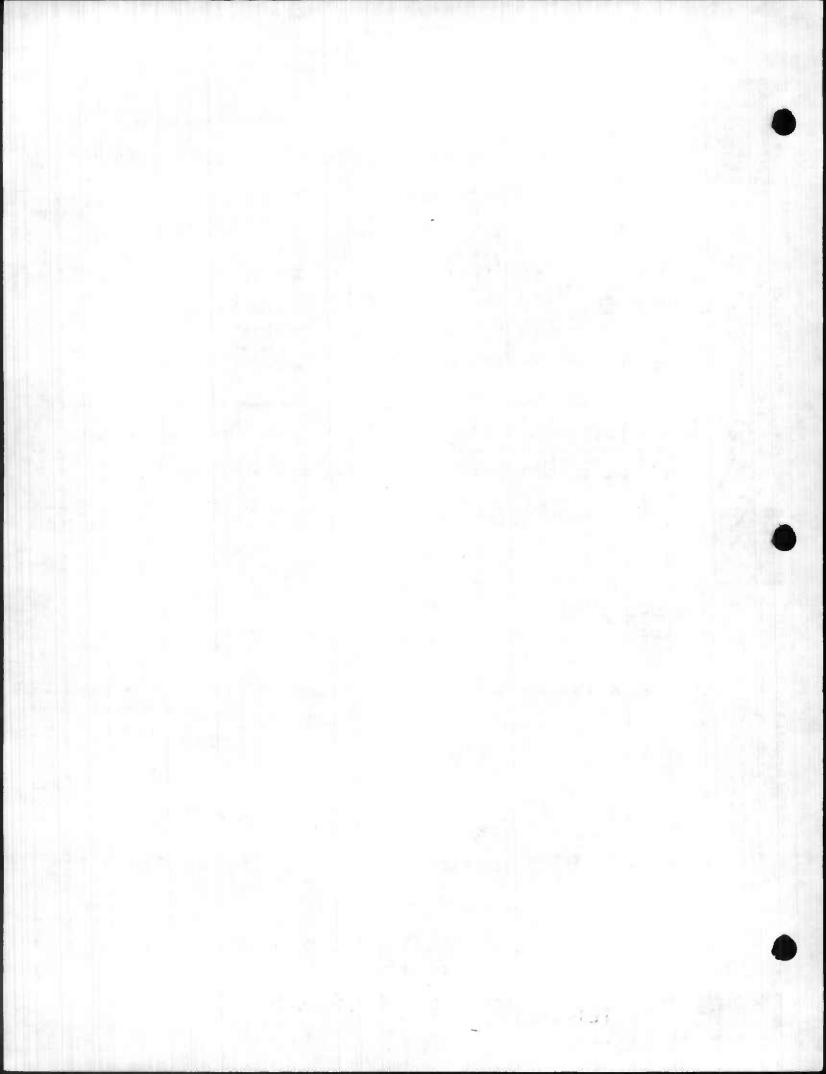
Little Patuxent Pkwy, Columbia, Md. 21044 M.D., 11085 Jerome Hantman,

31. Date filed (Month, Day, Year)

FEB 2 2 2000

32. Registrads Signature oaks

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\begin{align*}
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Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month Day Year 17, 2000 6:40 AM 4c. County of Death Elizabeth F Friend FEBRUARY 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Davs Months Hours 1 M 2 KF 145-16-9862 76 09 09 1923 PA Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yas 2 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 119F Versailles Circle 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Resident Manager Apt. Complex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. French Emily LeConey 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Murray Friend/Husband 119F Versailles Circle, Towson, Md. 21204 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State ery, cremetory or other place) Crem 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington 02 18 Baltimore, Md 21. Signeture of Furnish Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, List only one cause on each line. Balto, Md. 23a. Pert1. Enlar the chass shock, or heast failure. Approximate Interval Between Onset and Deeth Immediata Cause (Final MYOCARDIAL INFARCTION 9 DAYS diseese or condition resulting in death) Due to (or as a consequenca of): CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably € Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 20 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) USUnpatient 2□ ER/Outpatient 3□ DOA 28e. Dete of Injury (Month, Dey Year) Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending

the death certificate be associated and Box 68760. the USB signed by the a P.O. Records, page 2 certificate of Vital or Attending Physician: director. this funeral Division After

Examiner Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

10a State

Md

Director

Funeral

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Completed

Be

Funeral

Director

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Norma 23a

r than "natural", or han

Hygiene.

Pages 1 and 2 should be nant of Health and Mental is marked

Department of Health is Important: If Item 27 is any injury or other tra

Physician /Medical

Examiner

72 hours after

Saltimore, Maryland 21215-0020

deeth. after deeth Director: 2 filled in 24 hours a Hospital completely 2

edicai within 2 To the

State

DHMH 16 Rav 6/95

Registrar

BOON P. LIM, M.D., 31. Date filed (Month, Day, Year)

investigation

6 Could not be determined

2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of cart file

32. Registrar's Signature Denerous

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

7601 OSLER DRIVE, TOWSON, MARYLAND OBs. Ken

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D37254

1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

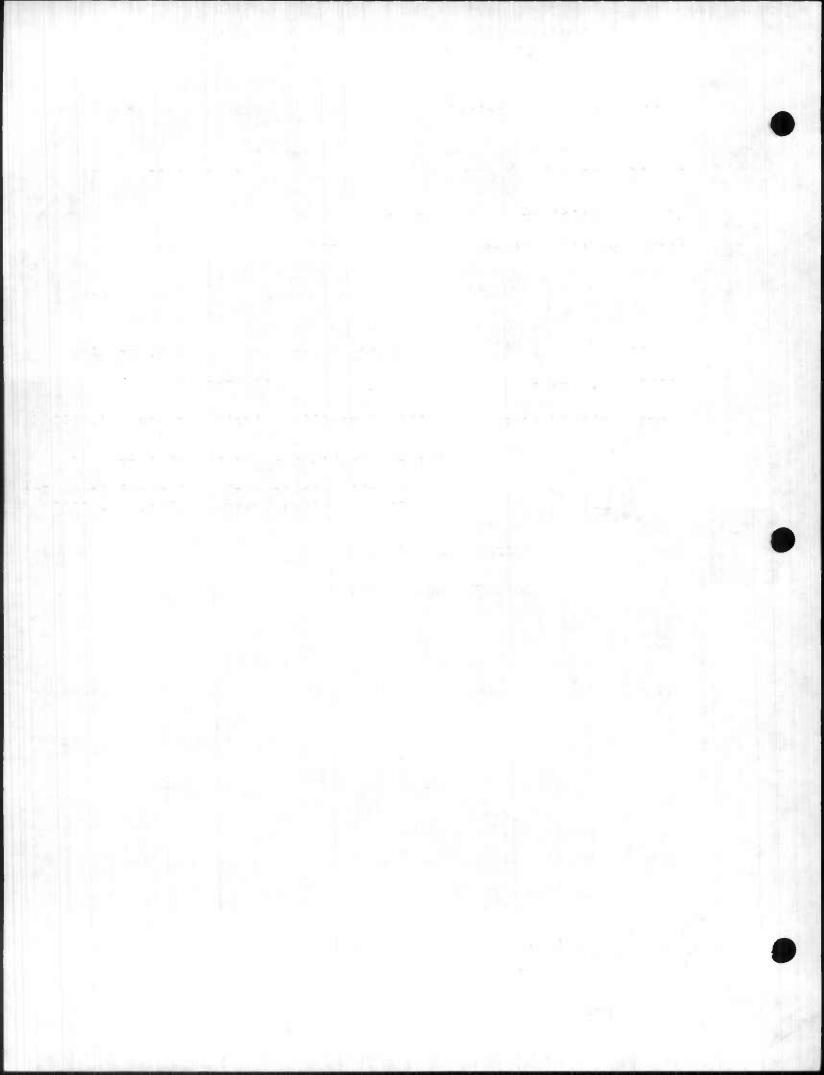
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30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

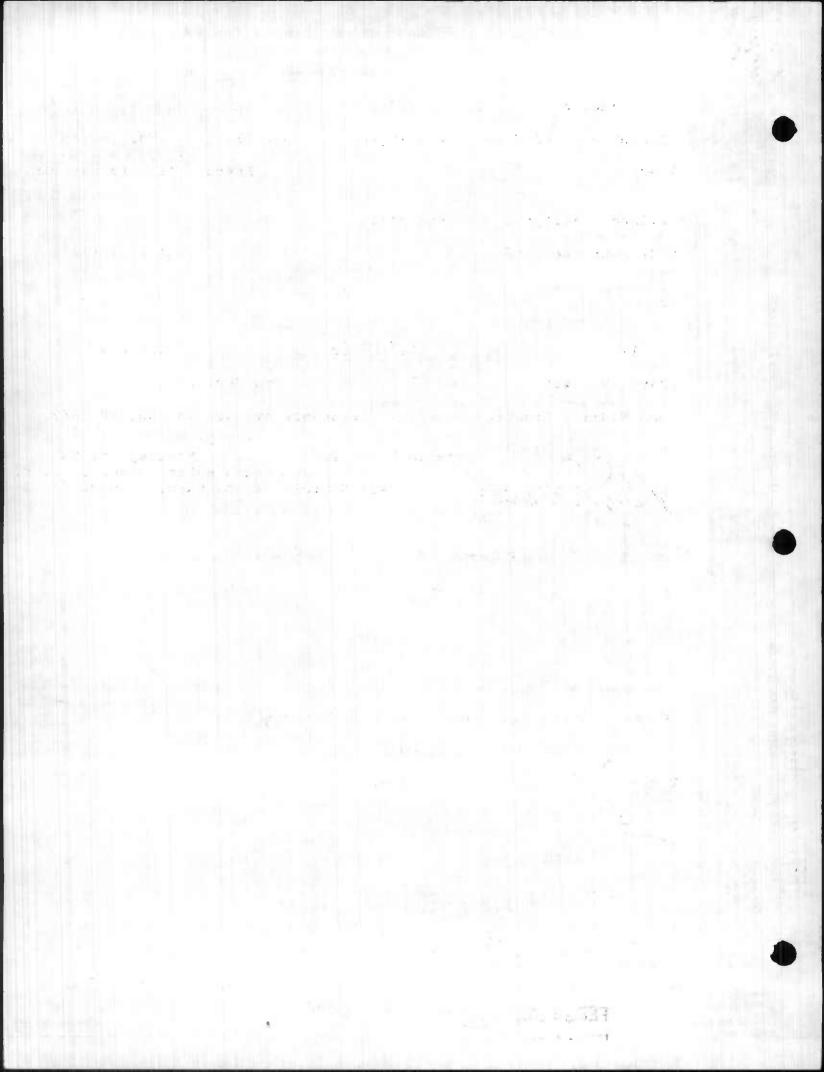


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Yaar **Physician** 19 14 15 Annette S. Fried Feb 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 9 0 9 9. Birthplaca (State or Foreign Months, Days Hours Min. (Month, Day, Year) 9. Birthplaca (State or Foreign Country) **Funeral** 1 M XXF Yrs. 90 November 11, Pennsylvania 190-36-5857 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f shortine Medical Examiner must be notified at XIXYes 2 No Directo Maryland Rockville Montgomery 10e Street and Number 10f. Zio Code 10g, Citizen of What Country? 6121 Montrose Road 20852 United States Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedant Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status hours efter 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ified within 72 if Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker i. Pages 1 and 2 should be filed with ment of Health end Mental Hygie tant: If Item 27 is marked other talury or other traumatic event, in other 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Be David Sadowsky Zara Horwitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Modlin/ Daughter 5215 Strathmore Ave Kensington, MD 20895 altimore, F EBe 2 1 20c. Location - City or Town, Stata 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Pemple B'nai Israel 2000 McKeesport, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stein Hebrew Memorial F. tice Libensee 232 Carroll St. NW Washington, DC 20012 aunos Enlaying disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or point failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Cardio -Examiner Due to (or es a consequence of): Examiner sician and burial-transit Sequentially list conditions, it any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in daath) Last Due to (or es a consequence of): certificate be axecu Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) the attending p Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 1 Unknown signed bed bed 15chemia þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed interstitual page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No disease tension Chron's Hospital or Attending Physician: Be 25. Was cese referred to medical axeminar? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P o funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred Division 5 Pending 1 Netorei after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Sulcida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide 24 hours Lecritying Physician: To the best of my knowledge, death occurred at the time, dele end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 24 hou To the Fune completely fi edicai å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13 0:44907 Tonsuel 7000 30. Name and address of person who completed ceuse of death (Ilem 23a) (Type, Print) CONSUETO Monnos, my Road Mon Rocklink 085 Trose 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 2 2000 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

| | | , | Certifi | cate of | Death | | Reg. No. | 00396 |
|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------|---------------------------------|------------------------------------------|------------------------|-------------------|-----------------------------------------------|
| | 1. Decedent'a Name (First, Middle, La | st) | | | | 2. Data of De Month | | 3. Time of Death |
| Physician /Medical | VIRGINIA WE | ISSEN FOGA | RTY | | | | ARY 18 | |
| Examiner | 4a Facility Name (If not institution, give | a street and number) | | | 4b. City, Town, or | Location of Deatl | 4c. County | |
| | 9108-WIRE AV | ENUE | | | SILVER | SPRING | 1 | MONTGOMERY |
| Funeral | Social Security Number 6. S | | Mc | Undar 1 Yaar onths Days | If Under 24 Hrs Hours Min. | 8. Date of Bir | | Birthplace (State or Foreign Country) |
| Director | 370-03-2422 | □M 2₹F 9.7 | Yrs. | | | JULY | 9, 1902 | EDINBURG, V |
| | Usual Residence of Decedent 10a. State 10b. County | 100.0 | ity, Town or Location | 10 | | | | 10d. Inside City Limits |
| show stat | | GOMERY | | | n anntu | | | 1∰ Yas 2 No |
| be nour so Director | | GOMEKI | | | R SPRIN | G | | X |
| MARYLAND MONT 10e. Street and Number 9108 - WIRE A | | | 1 | Of, Zip Coda | | | 10g. Citizen of V | vnat Country? |
| s 23a | | | | | 0901 | " " | | STATES |
| lear Per m | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U,S. 13. Was | Decedent of I s, specify Cub | Hispanic Origin? (S an, Maxican, Puer | to Rican, etc.) | Biac | e - American Indian, k, White, etc. |
| *natural; or | 1. Never Married 2 Married | 1 ☐ Yes € No If Yes, Give | 10 | Yes 2₽No | Specify: | | Specify | |
| | Widowed 4 □ Divorced | Yaar or Dates: | 16e. Decedent's | Α. | | | 40h Klad of D | WHITE |
| | 15. Decedent'a E (Specify only highast gro | ducation ada completed) | during most of wo | rking | 160. King of bi | usinass/industry | | |
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| Z should be ill a marked oth aumatic even To Be | 17. Father's Name (First, Middle, Last | 1 | | | | me (First, Middle | | |
| | Joseph Russ | | | | | ia Virg | | ishen |
| | | | 40h Mailine A | ddaaa (Ctaa | t and Number or R | | | |
| | 19a. Informant's Neme/Relationship (| | | | | | | |
| f Heelth frem 27 i | Carol Guthrie Owi | | Placa of Disposition | | nd Rd. H | FEBPata 23 | | City or Town, Stata |
| | 1 X Burlal 2 Cremation 3 | Repreval from State | cametery, cremato arklawn M | ry or other pla | Cel/ | 2000 | | lle, Maryland |
| tant: jury | 4 □ Donation 5 □ Othe (Special | | | | 1 | 2000 | KOCKVI. | tie, maryiand |
| Depertment of Important: If any Injury or once. | 21. Signature of Eatheral Service Lipte | 1800 | 22. Na | me and Addre | ess of Facility Ta | akoma Fu | neral Ho | ome |
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| | 23a. Part. Enter the durant, or comshock, or heart failure. List only | plications that caused the de- one cause on each line. | ath. Do not enter th | e mode of dyl | ng, such es cardie | c or respiretory a | rrest, | Approximate Interval Between |
| nysician | | | | | | | | Onset and Death |
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| the at thed for | Part II. Other significant conditions | ontributing to death but not re | sulting in the under | lying cause gi | ven In Part i. | 23b. Dld | tobacco uss co | ntributs to the cause of death |
| Phy th | | | | | | 1 🗆 | Yes 20 No | 3 Probably 4 Unknow |
| be de de by P | | | | | | | | |
| page 2 should | | | | | | 24a. Was | an autopsy | 24b. Were autopsy findings available prior to |
| 2 sh | | | | | | | | of deeth? |
| page 2 s | | | | | | 10 | Yas 20 No | 1 ☐ Yes 20 No |
| is certificate he director, page To Be Com | 25. Was case referred to medical | | | | 26. Place of De | ath (Check only | ône) | |
| I direc | axeminer? | Hospital: 1 ☐ Inpatient 21 | ☐ ER/Outpatient 3 | DOA Ot | her: | Home 5 Res | | ner (Specify) |
| | 27. Manner of Death | 28a. Data of Injury (Month, Day Yaar) | 28b. Time of Injury | | how injury occur | | | |
| the fun | Natural 5 Pending investigation | ryat ork?]Yes 2 ☐ No | | | | | | |
| is effer death. al Director: Affert led in by the funera Certification: | 2 Accident investigation M 1 Yes 2 No 3 Sulcide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office | | | | | | | per or Rural Route Number, |
| Dir. | 4 Homicide | building, etc. (Spec | cify) | | | City or To | wn, Stete) | |
| fille C | 29e, Certifier 19 Certifying Pt | ysician: To the best of my kr | owledge, deeth occ | curred at the ti | ime, dete end piac | e, and due to the | cause(s) and m | anner as stated. |
| he Funer pletely fill edical | (Check only 2 Medical Examone) | niner: On the basis of exeminand manner stated. | ation end/or investi | getion, In my | opinion, deeth occ | urred at the time, | date and pleca, | and due to the cause(s) |
| within 24 hours enter deam. To the Funeral Director: After th completely filled in by the funeral Medical Certification; | 29b. Signature and title of certifier | | | 29c. Licen | se nu <i>m</i> ber | | 29d. Dete algne | d (Month, Day, Year) |
| s 1- 0 | · 41 | TIT P. KURUS | III (AN.1) | n A | +6187 | | 02/20 | 12000 |
| | 1 | 4 | 1 | | TOIGT | | 02/20 | 12000 |
| 6 | 30. Name and address of person who | | em 23a) (Type, Prini /2 ROC | | 5 1.11- | Rock | 11 | 10 2200 |
| | DA IL L'ECKCOCI | CCH, MID 11 | LI KUC | COIL | - TIPE | LICE | -VILLE | MU JUS |

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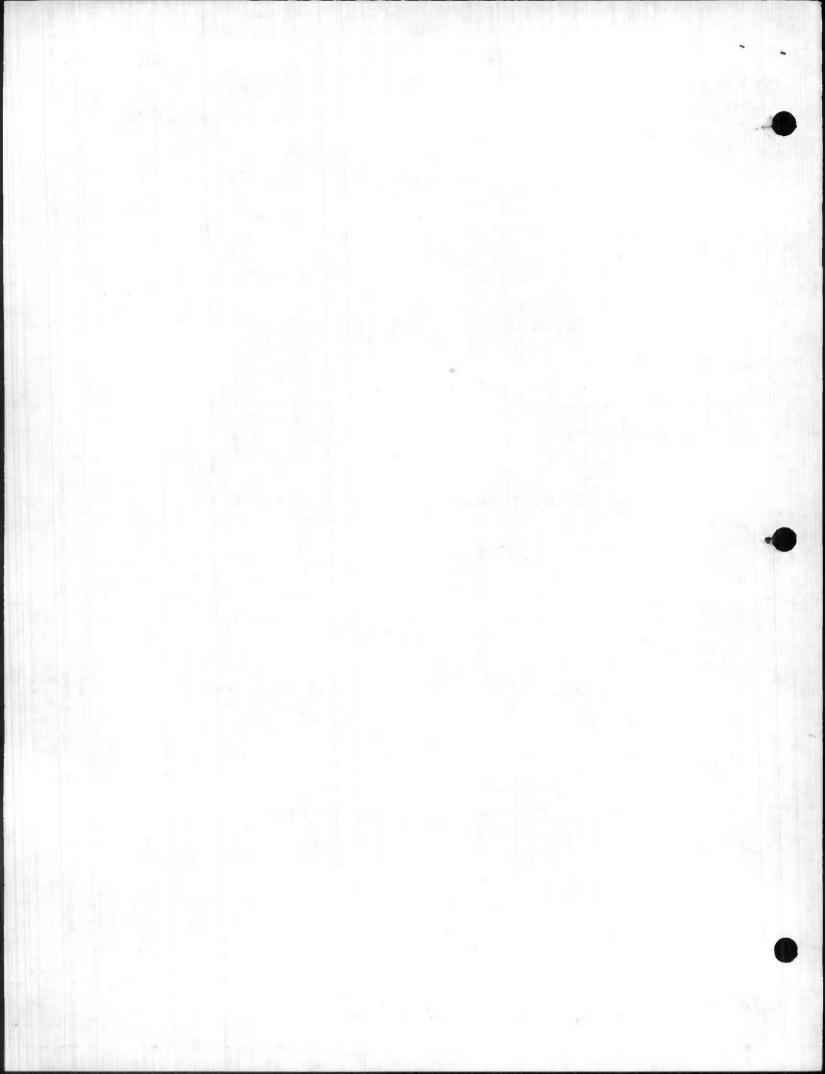
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Virginia Margarite **Physician** 10:10 p.m. 18, 2000 Feb. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Genesis-Elder Care Randallstown Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. lest birthdev) If Under 1 Year 8. Dete of Birth (Month, Day, Year) **Funeral** Months Devs 088-14-1126 Director 86 Dec.6, 1913 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 28a-f show 1 Yes 2 □ No Director Maryland Baltimore 8 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code b 3705 Sequoia Avenue 21215 United States Nems 23s 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give 14. Rece - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, apecify Cuban, Maxican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 natural, or Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greds completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) unknown Riveter Defense Contractor marked other 17. Father's Neme (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Sumeme) Be Pages 1 and 2 should be 1 nent of Health and Mental int: If flam 27 is marked of Jeffries James Frances (unknown) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Harold V. Sullivan, Jr. (Son) 9817 Kerrigan Court Randallstown, MD 21133 mportant: If Nam 27 iny injury or other tr 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete | Burial 2 N Cremetion 3 | Removal from Stele | Comercity of Office | Possible | Crematory | 02/21/2000 Laurel, Maryland | Donation 5 | Other (Specify) | Baltimore-Washington Crematory | 02/21/2000 Laurel, Maryland 22. Nama and Addrass of Fecility Loring Byers Funeral Directors 21. Signatura of Funerel Service Licensee ellner 8728 Liberty Rd. Randallstown, MD21133-4784 11,00 J 33 23a. Pag. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, nck, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical immediate Cause (Finei THEROSCIENUTE CANDIOVASCORAN disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) 987 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably W Unknown OBSTALLETIVE Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed No 1 Yes AND 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifical completely filled in by the funeral director, 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 5 Residence 8 Other (Specify) Certification: To 1 Yes 20 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magrand D 28c. Injury et Work? 28d. Dascribe how Injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 1 E Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier edical (Check only one) 29b. Signeture and title of certifier 29c. License numbe 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Dey, Year)

32. Registrer's Signeture



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 15398 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Vear Month Physician FEB 19 6:15 PM Alverta Glover 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Deaton Medical Center Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1□M 2XF 82 Yrs. 249-20-3393 09/09/1917 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10e. State 10b. County 10c. City. Town or Location Wes 2□No r 28a-f st notified Directo MD Baltimore City 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number en "netural", or items 23s or Medical Examinar must be **USA** 1218 N. Bentalou St. 21216 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: g 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Entertainer/barmaid night club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Edward Snowden Annet Thomas 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Department of Health Important: If Item 27 Theodore Glover/ Husband 1218 N. Bentalou St. Balto. Md 21216 20a. Method of Disposition
1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Pages ò 4 ☐ Donation 5 ☐ Other (Specify) Chesapeke Crematory 02/22/00 Beltsville,MD 22. Name and Address of Facility
CAFA Stephen D. Lohrmann PA 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr Towson, MD 21086 Approximate Interval Between Onset and Death **Physiclan** /Medical Immediate Cause (Final Aspiration pheummin 4 days disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Physician/Medical Examiner disease obstructive 1648 death certificate be executed physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequenca of): Due to (or as a consequence of): 88 for use as 23b. Did tobacco use contribute to the cause of deeth? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. The law requires that the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown noxic enconhalanathy þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed has 928 page 1 Yes 2 No 1 ☐ Yes 2 1 No certificate Physician: 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 26b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After t Certification: or Attending 5 Pending investigation n 24 hours after death.

Funeral Director: Aft bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated. 29a. Certifier edical (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Non D30494 2-40-2000

south charles St Baltimore MD & 1230

Registrar

State

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

CONV

32. Registrar's Signature

611

Deston medical

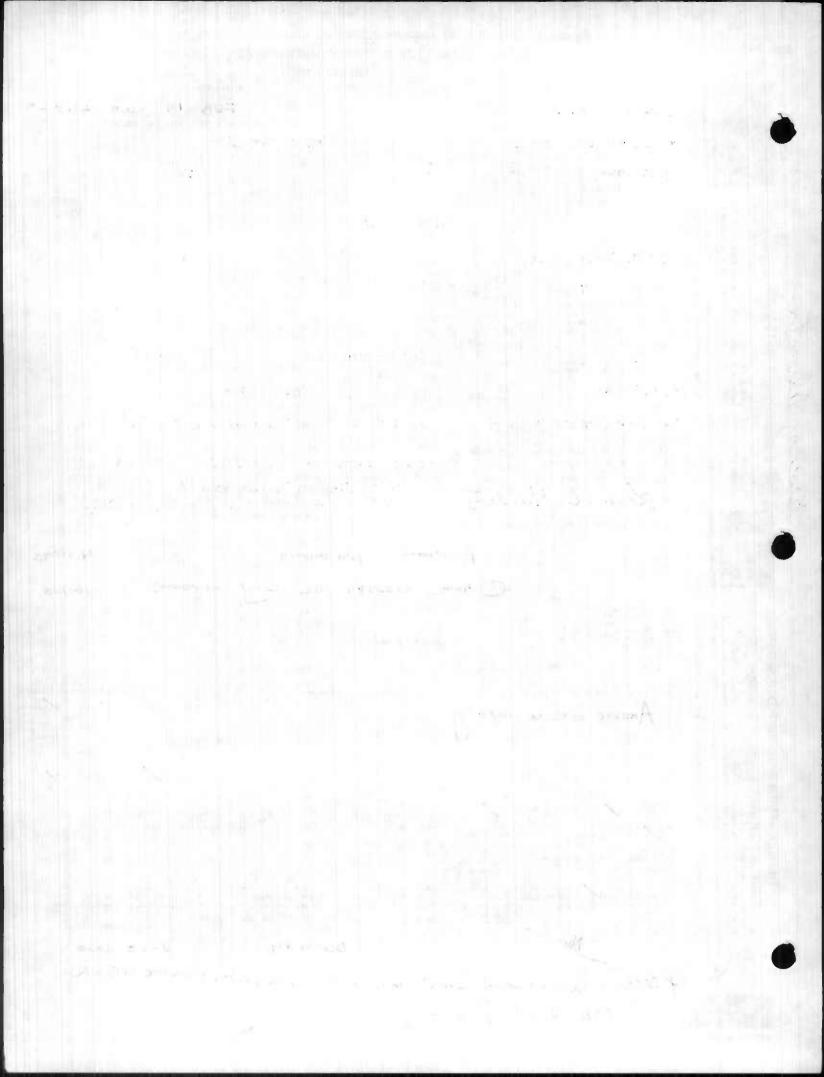
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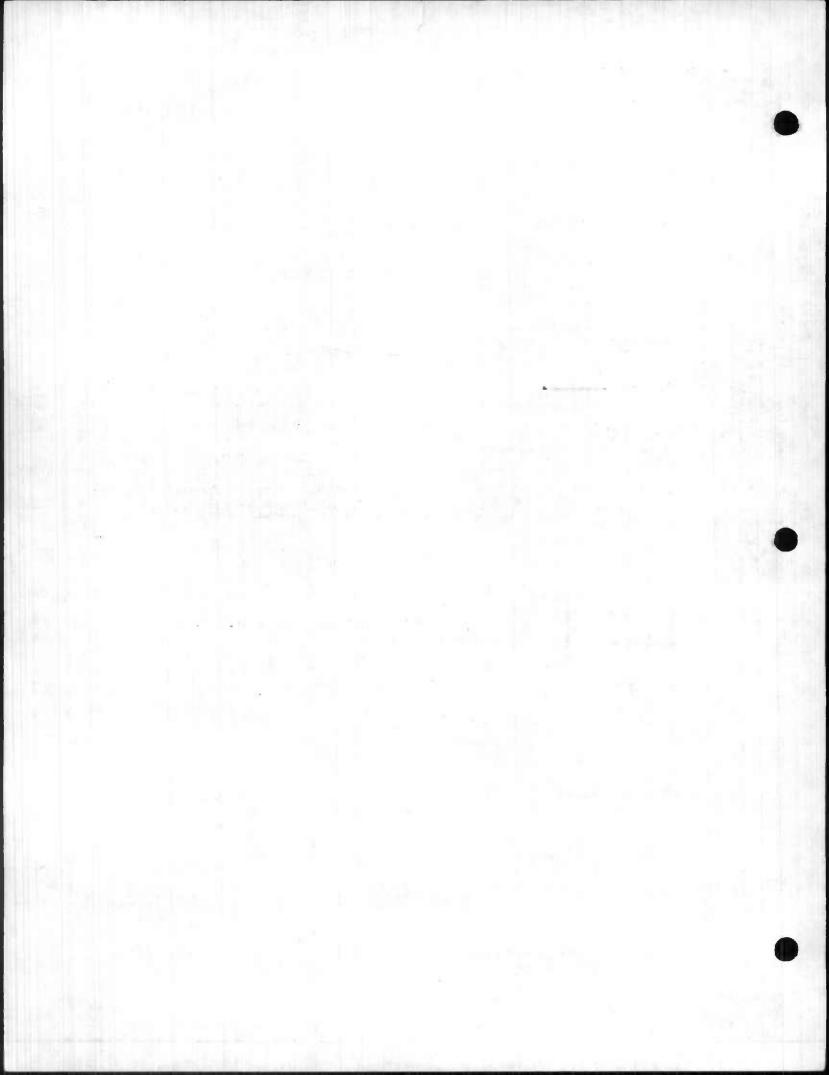
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| Amended | Item#17 perFHG781 3/3/2 | State of Maryla | | artment of F rtificate of | | Mental Hy | /giene [] [] | 05 | 5399 | |
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| Amended | 1. Decedent's Neme (First, Middle, La | | | | | 2. Date of D | eath | | 3. Time of Death | |
| Physician /Medical | Marie Karl Zelle | r Goodwin | | | | FEBEV | ARY 20,3 | 1000 | 8:15 PM | |
| Examiner | 4a Facility Name (If not institution, giv | | 41. 66 | | 4b. City, Town, or L ROSE | ocation of Dea | th 4c. County | of Deeth | Inork | |
| Firmanal | FRANKLIN S PUA 5. Social Security Number 6. S | ex 7. Age (In yrs | last birthday) | If Under 1 Year | If Under 24 Hrs. | | | | | |
| Funeral Director | 214-12-0310 | DM 2DF 86 | | Months Days | Hours Min. | 8. Date of Bi (Month, D | ay, Year) | Countr | nce (Stete or Foreign y) | |
| 9 | Usual Residence of Decedent | | | | | Treb. | 4,1714 | mary | ranu | |
| nylan nhow | 10e. State 10b. County | 10c. C | ity, Town or Lo | ocation | | | | 100 | d. Inside City Limits | |
| oto de de | MD. Balti | more | Cha | | | | | | 1 ☐ Yes 2 ☐ No | |
| death with the Maryland ma 23a or 28a-f show marst be notified at neral Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of W | Vhet Countr | y? | |
| ath v | 140 Rodeo Dr. | | 10 1.0 | | 220 | | USA | | | |
| 5 28 5 | 11. Merital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U Armed Forces? 1 Des 2 Also If Yes, Give Year or Dates: | les? If Yes, specify Cuban, Mexican, Puerto less. 1 ☐ Yes 2 ☑ No Specify: | | | | y Yes or No- an, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: White | | | |
| 72 hours "netural". | 15. Decedent's Ed | lucation | 16a. Dece | dent's Usuel Occup | pation | | 16b. Kind of Bu | | | |
| | (Specify only highest gra | de completed) College (1-4or 5+) | (Give | kind of work done DO NOT use retire | during most of work d) | ing | | | | |
| Manual Po | Liementery/Secondary (0-12) | College (1-401 5+) | I | Homemaker | | | Own 1 | Home | | |
| aryland 21215-0 should be filed within 72 ho of Mental Hygiens. marked other than "nature marke event, the Medical To Be Completed | 17. Father's Neme (First, Middle, Last) | e (First, Middle | e, Meiden Sumem | e) | | | | | | |
| arylar should by and Mente of urmatic e | John Karl Coodwin | - | | | Margan | et Sch | lee | | | |
| Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event | 19a. Informent's Name/Reletionship (| Type, Print) | 19b. Maili | ng Address (Street | and Number or Rui | ral Route Numb | ber, City or Town, | Stete, Zip C | Code) | |
| end nazy | Rose Marie Maszor | -Daughter | 140 | Rodeo Dri | ve Chase | MD. 2 | 1220 | | | |
| Baltimore, Mar pemit. Pages 1 end 2 sh Department of Heelth and Important: If them 27 is m any injury or other traum ands. | 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremetion 3 🗆 4 🗆 Donation 5 🗆 Other (Specific | Dameuel from State | cemetery, cre | metory or other piac | er Cemeter | | | | n, State | |
| Balt pemil: Depart Import import eny inj | 21. Signeture of Funeral Service Licer | 1/ - | M | 2. Neme end Addre | on Dohmon | vski Fu | neral Ho | me, In | | |
| | 23a. Part 1. Enter the disease, or comshock, or heart letters. List only | plications thet caused the dea | th. Do not en | ter the mode of dyir | ng, such as cardiac | or respiretory | errest, | Md · Z | 1 2 2 4 Approximate Intervel Between | |
| Physician | | | | | | | | | Onset end Death | |
| /Medical Examiner | Immediate Cause (Final disease or condition | . A NOTIC | ENG | FPHA | LOPATH | +4 | | | 2 DAYS | |
| | resulting in death) | a. A NOTIC Due to (| | | | - | | | | |
| B # C | | b. CARDIO 6 Due to (| ENIC | SHOC | K | | | 16 | 2 DAYS | |
| 8760, ste be specuted hysician and the buriel-transit | Sequentially list conditions, if any, leading to immediate | | | | | | A . | | 2 0 4 40 | |
| 8760, ste be say the buriel the buriel dical Ex | cause. Enter Underlying Cause (Disease or injury that initiated events | C. ACUTE | | | H INI | =ARCT | 100 | 1 0 | - IJA/S | |
| 68 ifficate g phy as the | resulting in death) Last | Due to (| or as a consec | juence or): | | | | | | |
| Box atth cert for use | | d | | | | | | - | | |
| deat de la la la la la la la la la la la la la | Part II. Other significant conditions of | ontributing to death but not re- | sulting in the u | nderiving cause oix | ven in Part I | 23b. Did | tobacco use cor | ntribute to 1 | the cause of death? | |
| P.O. net the de d by the estached Physic | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | |
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| Division of Vital Records, P.O. Box 68760, or Attending Physician: The lew requires that the death cardificate be associated after death. Director: After this cardificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burisi-transit ertification: To Be Completed by Physician/Medical Examir | STRUCTIVE | STRUCTIVE PULMONARY DISEASE | | | | | | | e autopsy lindings lable prior to upletion of cause eath? | |
| S de de de de de de de de de de de de de | | | | | | 10 | Yes 2000 | 10 | Yes 2□ No | |
| of Vital Re Physician: The in This certificate had director, page 1: To Be Com | 25. Was case referred to medical examiner? | | | | 26. Place of Deel | th (Check only | one) | | | |
| To To | 1 Yes 2 No | | ER/Outpatie | | 4 LI Nursing m | ome 5 Res | sidence 6 Oth | er (Specify) |) | |
| ng Pl | 27. Manner of Death 1 ☑Neturel 5 ☐ Pending | 28a. Dete of Injury (Month, Day Year) | 28b. Time o Injury | f 28c. Injui | rk? | 28d. Describe | how injury occurr | red | | |
| Vision Attending or deeth. ector: Afte by the tune | 2 Accident investigation 3 Suicide 6 Could not be | | | M 1 | Yes 2 No | | | | | |
| Division (be or Attending P m after deeth. al Director: After led in by the tunent Certification: | 4 Homicide determined | 28e. Place of Injury - At I building, etc. (Speci | iome, ferm, st ify) | reet, fectory, office | | | (Street and Numb own, State) | er or Rurel | Route Number, | |
| New Parket | On Cadifical at the att to me | | | | | | 45.4 | | | |
| Division of To the Hospital or Attanding Phywithin 24 hours after deeth. To the Funeral Director: After this completely filled in by the tuneral director Medical Certification: To | 29e. Certifier 1 Certifying Ph (Check only 2 Medical Examone) | ysician: To the best of my known the common the basis of examinating and manner stated. | owiedge, deat ation and/or in | n occurred at the tir vestigation, in my o | me, date end place, opinion, death occur | end due to the red et the time | cause(s) and ma date end plece, a | nner as sta and due to t | ited. the cause(s) | |
| Me this | 29b. Signature and title of certifier | A | | 29c. Licens | e number | | 29d. Date signed | d (Month, D | Pay, Year) | |
| F 3 F 8 | 12. Class | le no | | P | D# 19, | 1825 | 2/20/0 | 90 | | |
| 5 | 30. Name and address of person who | completed cause of death (Ite | m 23a) (Type, FRAL | Print) | OUARR D | 9 | RATA | 10 | 21127 | |
| - | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | | 1 | | h . / | וןיוטתי | (1) | 01001 | |
| State Registrar | FEB22 | 2000 Denn | | y spa | da | | | | | |
| DHMH 16 Rev 6/95 | BANG - C | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Year auvenc 2000 ong las 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltomore Wings If Under 24 Hrs. -0992 41115 Deer 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) / 1 Days Hours Min. 1 M 2□ F Months 30-44-1884 6-1936 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yas 2 No Balto Ma Wings 10e. Sireel and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 0 odge Court 2-1117 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 20 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Yaar or Dates 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Saw Elementary/Secondary (0-12) Collega (1-4or 5+) abover 12th grade NA 17. Father's Name (First, Middle, Last, 18. Mothar's Name (First, Middle, Maiden Sumeme) Smith Nao 4 -er Jarland Gaskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Apt A Owings Mills, MD 21117 Deer odge 20b. Pleca of Disposition (Nema of cemetery, cremetory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cemetery 126/00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

March Funerod Home Baltimore, MD 21215 4300 Wabash Avenue Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata tntarval Between Onset and Deeth Immediate Cause (Final differentiated 10 months disease or condition resulting in death) lung covariona Dua to (or as a consequence ot): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequance of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tos 2 No 3 Probably 4 Unknown Prostate Concer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? chronic dostructue pulmousy disease 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yes 25. Was case ratarred to medical axaminar? 26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

2/21/2000

Physician /Medical Examiner

be executed

The law requires that the death certificate

Physician:

or Attending

Box 68760.

P.O.

Division of Vital Records.

Department of Health a Important: If Nem 27 Is any injury or other tra DAGS.

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

8

Funeral

Director

r than "natural", or itsms 23s or 28s-f show the Medical Examinar must be notified at

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after name of Health and Mental Hygiene.
Int. If Item 27 is marked other than "natural", or its

Baltimore, Maryland 21215-0020

2 After 3

PhysiciaryMedical Examiner this

Completed by Be Medical Certification: To

s after death. lilled in To the Hospital o within 24 hours af To the Funeral Di completely lilled i

Registrar

State

31. Daie filed (Month, Day, Year)

1 Yes 2 No

27. Manner et Death

1 Netural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only onel

29b. Signature and little of certil

FEB 2 2 2000

30. Name and address of person white Dr Harry Cu. Kaplan, 10

5 Pending Investigation

6 Could not be determined

mpleted cause of death (Item 23a) (Type, Print) 90 Painters Mill Rd. Suite 126; Owings Mills, MD 21117 32. Registrar's Sgnature

100

28a. Date of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

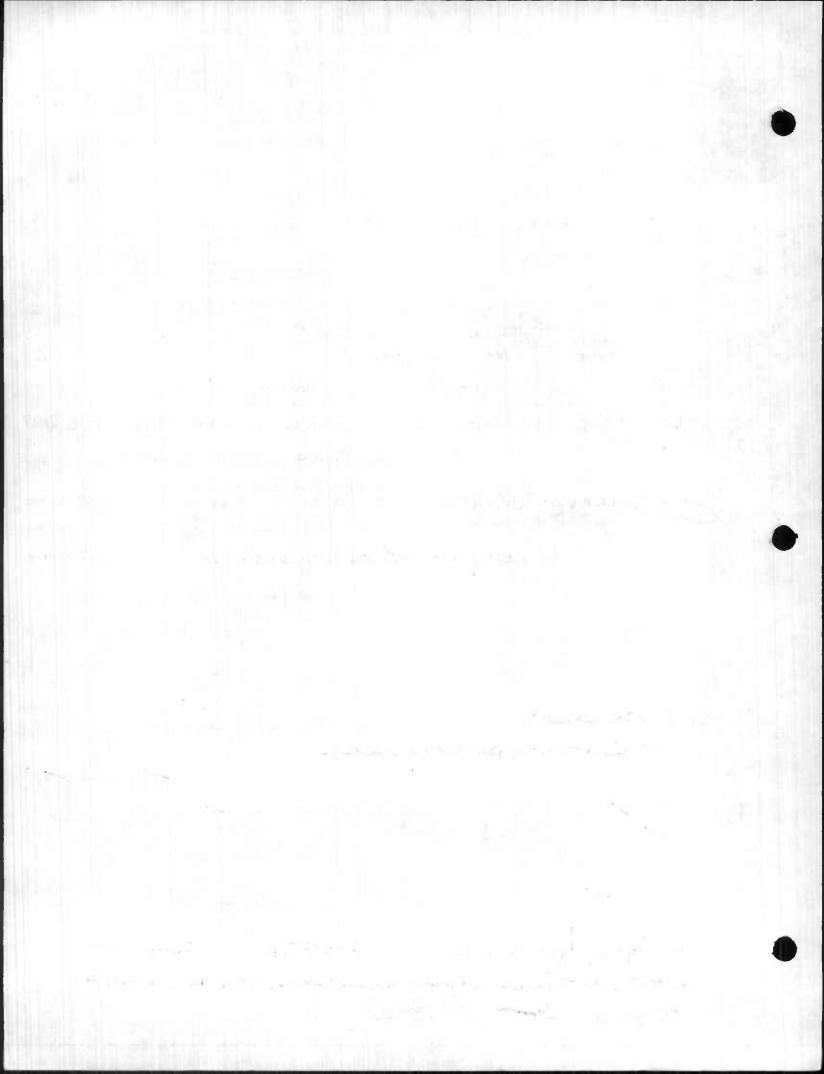
28c. Injury at Work?

29c. License number

D403

1 Certifying Physician: To the best ot my knowledge, death occurred at the time, data and place, and dua to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

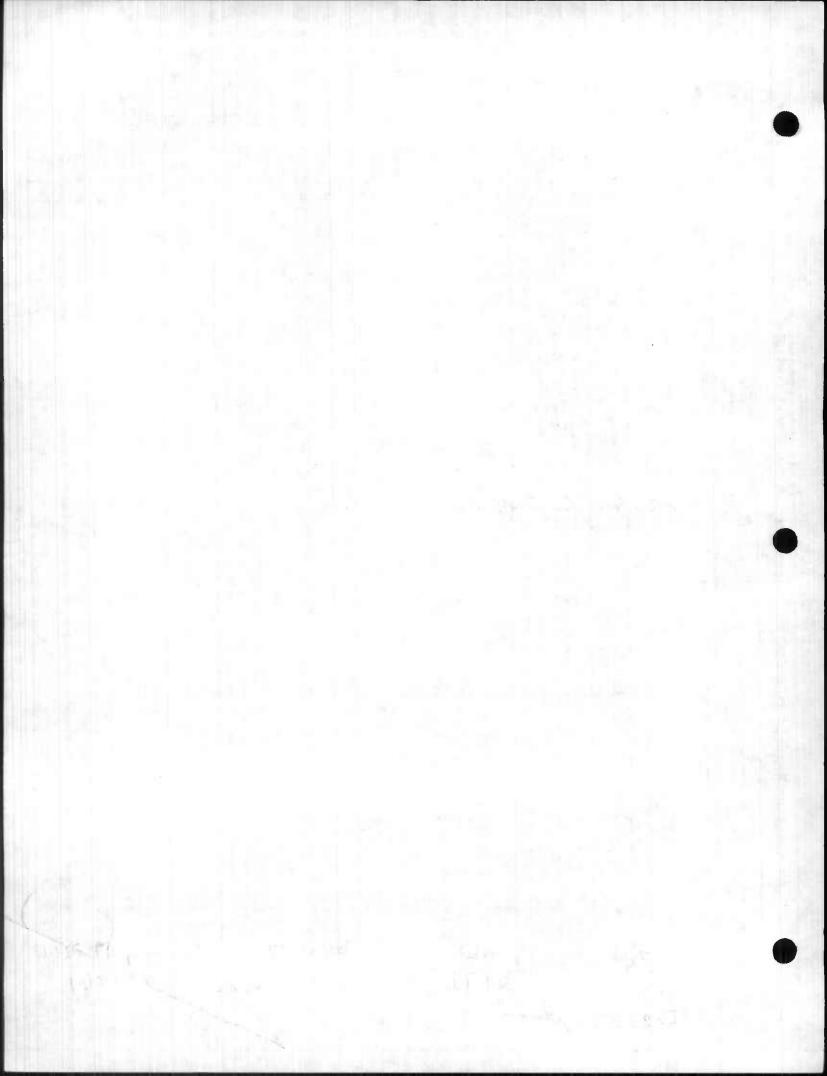
1 Yes 2 No



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State of Maryland / Department of Health and Mental Hygiene 0 0 5 4 0 1

| | | | | Certifi | cate of | Death | | Reg. No. | | |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------|--------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|
| | 1. Decedent's Neme (First, Middle, L. | est) | | | | | 2. Date of D | | Yaar 3. Time of Dea | |
| ician dical | William C. Grove | S | | | | | Feb | 17 20 | 000 6:100 | |
| niner | 4a Facility Neme (If not institution, gi | ive street end number) | | | | 4b. City, Town, | or Location of Dea | th 4c. County | | |
| | NORTH ARUN | JDEL H | 0501 | TAL | | SIEN T | BURNIE | AAC | YTHUDE | |
| | 5. Social Security Number 6. | Sex 7. Age | (In yrs. last | | Under 1 Year onths Deys | | lin. (Month, D | irth ley, Year) 30,1923 | 9. Birthplace State or Fo. Country) West Virgin | |
| - 1 | Usual Residence of Decedent | | 10- Ob T | | | | | | 1404 5-14-05-14 | |
| - | MD Anne A: | runde1 | | own or Locatio | | | | 10d. Inside Cil | | |
| Directo | 10e. Street and Number | | 02011 | | of, Zip Code | | | 10g. Citizen of V | Vhat Country? | |
| | 515 Dover Road | | | | 21061 | | | U.S.A. | | |
| Funeral | 11. Marital Stetus | 12. Was Decedent E | ver in U,S. | 13. Wes | Decedent of I | lispanic Origin | (Specify Yes or Nuerto Rican, etc.) | | e - American Indien, | |
| by | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Detest. | o(UN- | | res 2∭ No | | Jerro Hican, etc.) | Specify | k, White, etc. White | |
| 201 | 15. Decedent's E | 6a. Decedent's | Usuai Occu | pation | wating | 16b. Kind of Bu | siness/Industry | | | |
| Completed | (Specify only highest gi | College (1-4or 5- | (4 | life. DO N | OT use retire | during most of d) | working | | | |
| 000 | 12 | | Railro | ad Eng | ineer | | Railro | ad | | |
| 8e (| 17. Fether's Name (First, Middle, Las | | | | 18. Mother's | Neme (First, Middl | e, Meiden Sumem | e) | | |
| 0 | Alfred H. Groves | 5 | | | | Mary | Chapman | | | |
| | 19e. Informent's Name/Relationship | (Type, Print) | 1 | 9b. Malling Ad | idress (Street | end Number o | Rurel Route Num | ber, City or Town, | State, Zip Code) | |
| | Betty Groves | (wife) | 5 | 15 Dov | er Roa | d, Glen | Burnie, | MD 21061 | | |
| | 20a. Method of Disposition | | 20b. Plece | of Disposition | Neme of | ce) | Date | 20c. Location - | City or Town, State | |
| | 12 Buriel 2 ☐ Cremetion 3 € 4 ☐ Donation 5 ☐ Other (Special | | | lowridg | | | Feb 19 2000 | Elkridge | e, MD | |
| Physician/Medical Examiner | disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Oces | Le 4 | a consequence a consequence | Da ce of): | dues | | | | |
| 20 | Part II. Other significant conditions | contributing to death bu | t not resulting | g in the under | ving ceuse gi | ven in Part I. | 23b. Die | d tobacco use co | ntribute to the cause of d | |
| E | | | | | | | 10 | Yae 2 No | 3 Probably 4 Un | |
| | | | | | | | _ | | | |
| p A | | | | | | | | s an eutopsy formed? | 24b. Were autopsy find available prior to completion of cau of death? | |
| | | | | | | | 10 | Yes 2 No | 1 Yes 20 No | |
| | | | | | | | | | | |
| Completed | 25. Was case referred to medical | | | | | 26. Place of | Death (Check only | one) | | |
| o Be Completed | examiner? | Hospital: 1. Inpatier | nt 2 ER/ | Outpatient 3 | DOA Ot | hor | Death (Check only | | er (Specify) | |
| To Be Completed | examiner? | 28a. Date of Injur (Month, Day | y 281 | b. Time of Injury | 28c. Inju | her: 4 Nursir | g Home 5□ Re | | | |
| To Be Completed | examiner? 1 Yes 2 No 27. Manner of Death 1. Naturel 5 Pending | 28a. Date of Injur (Month, Day | Year) 281 | b. Time of Injury | 28c. Inju Wo | her: 4 Nursir | g Home 5 Re 28d. Describe | sidence 6 Oth s how injury occur | red | |
| To Be Completed | examiner? 1 Yes 2 No 27. Maner of Death 1. Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation of determined | 28a. Date of Injun (Month, Day) | ry - At home (Specify) | b. Time of Injury | 28c. Inju Wo | her: 4 Nursir ry at rk? Yes 2 No | 28d. Describe 28f. Location City or T | sidence 6 Oth a how injury occur (Street and Numb own, State) e cause(s) and ma | red eer or Rurel Route Number | |
| redical certification. To be completed | examiner? 1 Yes 2 No 27. Manyer of Death 1. Disturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 No 27. No 5 Pending investigation 6 Could not light determined | 28a. Date of Injun on be d 28e. Plece of Injun building, etc. 28e. Plece of Injun building, etc. hyelclan: To the best of | ry - At home (Specify) | b. Time of Injury | 28c. Inju Wo | her: 4 Nursir ry at rk? Yes 2 No me, date and popinion, death c | 28d. Describe 28f. Location City or T | sidence 6 Oth he how injury occur (Street and Numbown, State) he cause(s) and mails, date end plece, | red er or Rurel Route Number | |
| redical certification. To be completed | examiner? 1 Yes 2 No 27. Manyer of Death 1. | 28a. Date of Injun on be d 28e. Plece of Injun building, etc. 28e. Plece of Injun building, etc. hyelclan: To the best of | ry - At home (Specify) | b. Time of Injury | 28c. Inju Wc 1 [actory, office urred et the tigation, in my | her: 4 Nursir ry at rk? Yes 2 No me, date and popinion, death c | 28d. Describe 28f. Location City or T | sidence 6 Oth he how injury occur (Street and Numbown, State) he cause(s) and mails, date end plece, | er or Rurel Route Number inner es stated. and due to the ceuse(s) | |



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State of Maryland / Department of Health and Mental Hygiene 00.05402

| | 1. Decedent's Name (First, Mid | Decedent's Name (First, Middle, Last) | | | | | | | | | | 3. Tima of Death | |
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| ledical aminer | 4a Facility Name (If not instituti | | | | | ORRIDDIC | T | own, or Lo | ocation of Death | - | y of Death | 0.50 2 | |
| | GENESIS ELDER | CARE | | | | | SEV | ERNA | PARK | ANI | NE AR | UNDEL | |
| eral | 5. Social Security Number | 6. Sex | | - | last birthday | /) If Under 1 Ye | | or 24 Hrs. | 8. Date of Bir (Month, Da | h V Vesri | 9. Birth | place (State or Foreign | |
| | 213-05-8658 | 1 M | 26 F | 86 | Yrs. | Month of Su | 110010 | | DEC. 1 | | | ECTICUT | |
| | Usuel Residence of Decedent 10a. State 10b. Count | ity | | 10c. Cit | ty, Town or L | _ocation | | | | | | 10d. Inside City Limits | |
| lor | MARYLAND ANN | E ARUN | DEL | | SEVER | RN | | | 1 □ Yes 2 No | | | | |
| Director | 10e. Street and Number | | | | | 10f. Zip Cod | • | | | 10g. Citizen of | What Cou | ntry? | |
| a D | 7725 TWIN OAK | S ROAD | | | | 2 | 1144 | | | U | .S.A. | | |
| Funeral | 11. Marital Status | | Was Decede Armed Force | | J,S. 13. | . Was Decedent of | f Hispanic O | rigin? (Span, Puerto | ecity Yes or No Rican, etc.) | 14. Ra | ce - Americ | can Indien, | |
| 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 4 17. Father's Name (First, Middle, Last) ROBERT 19a. Informant's Neme/Relationship (Ty) | | arried | 1 ☐ Yes 2 No | | | 1 □ Yes 20X | | | | Speci | | ITE | |
| | 15. Decede | ent's Education | on ampleted) | | 16a. Deci | edent's Usual Oc | upation | ast of work | ina | 16b. Kind of E | Business/In | dustry | |
| | | | College (1-4c | or 5+) | life. | DO NOT use rei | ired) | UL OF WORK | | DECET | 70.33 | | |
| | | 0.1004 | | | WALT | ress | 10 14-11 | nade M | o (Figure 8.67-4-4) | RESTAI | | | |
| | | o, LaSI/ | | HUNT | | | | zabet | e (First, Middle, าน | waruen Sumai | FRAN | CE | |
| | nship (Type | | | | ling Address (Str | | | | er. City or Town | | | | |
| | MRS. YVONNE DA | | | HTER) | 100 | 25 TWIN (| | | | | | | |
| | 20e. Method of Disposition | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 20b. F | Placa of Disp | osition (Name of | | 1 | Date | 20c. Location | | | |
| | 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (| | oval from Sta | ite est | | Memera AND | | -1 | 24/200 | | 7 T T T | MD | |
| | 21. Signeques of Fujarrith Service | | | PIAR | | VETERAN: 22. Name and Ad | | | T.ETON I | CROWNS | | | |
| | 1 Da | 1 | | | | | | | | | | | |
| | 1100001111 | | | | 1 | SECOND | WA PMO | E, S. | W., GLI | N BURN | IE, M | D. 21061 | |
| 1 | 23a. Pert1. Unter the disease, shock, or heart feilure. List Immediate Cause (Final disease or condition resulting in death) | orcomplications only only only only only only only only | ons that caus ause on each | sed the death | | | lying, such a | s cardiac | or respiretory a | | DE, MI | Approximate Intervel Between Onset and Death | |
| aminer | Immediate Cause (Final disease or condition resulting in death) | or complications only one can b. | ons that caus ause on each After Right | roscla | th. Do not er | Coron | lying, such a | s cardiac | or respiretory a | | DE, MI | Approximate Intervel Between | |
| l Examiner | Immediate Cause (Final disease or condition resulting in death) | or complications only one can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can be as a can | Aflen Right | roscle Due to 4 | th. Do not er | Coron equence of: | lying, such a | s cardiac | or respiretory a | | be. | Approximate Intervel Between | |
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| edical | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | or complications only one complications only one complications only one complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete com | ons that cause on each After Right Vus | Due to to Fe Due to (o | or as a conse | Coron equence of: He and He appears of: Device | lying, such a | s cardiac | or respiretory a | | be | Approximate Intervel Between | |
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DHMH 16 Rev 6/95

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1 SECOND AVENUE, S.W., --

| | | | | Certificate | of Death | | Reg. No. | 00403 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------|----------------------------------------|---------------------|------------------------------------------------|----------------------|------------------------------------------------|----------------------------------------------------|--|
| hysician | Decedent's Name (First, Middle | , Last) | | | | 2. Date of D | eath Day | 3. Time of Death | |
| /Medical | MARJORIE | ROULINE | | GOSS | | Debru | ian, 19 | 2000 8 72m | |
| miner | 4a Facility Nama (If not institution | , give street and number |) | | | or Location of Dea | th County | | |
| | Caton Mic | mor | | hdav) If Under 1 | Battin Yaar H Undar 24 H | | y | N/A | |
| al or | 5. Social Security Number | 6. Sex 7. A | ga (In yrs. last birt | | | fin. (Month, D | bg, Year) | 9. Birthplace (State or Foreign Country) WEST | |
| | 233-52-0080 Usual Residence of Decedent | | 66 | | | DECEME | BER 10,15 | 933 VIRGINIA | |
| | 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limits | |
| MARYLAND N/ 10e. Street and Number 625 BISCAY AVEN 11. Merital Stetus 1 Nevar Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent' (Specify only highest Elementary/Secondery (0-12) 12 17. Father's Name (First, Middle, L. GEORGE 19a. informant's Name/Relationsh | MARYLAND N | 'A | BALTIM | IORE | | | | 1 ☐ Yes 2 No | |
| | | | 10f. Zip 0 | Code | | 10g. Citizen of \ | What Country? | | |
| | 625 BISCAY AVE | IUE | | | 21225 | | U. | S.A. | |
| | | 12. Was Deceden Armed Forces | t Ever in U,S. | 13. Was Decede | nf of Hispanic Origin? y Cuban, Mexican, Pu | (Specify Yes or N | | e - American Indian, ck, Whita, atc. | |
| | 1 Nevar Married 2 Marr | | | 1 Yes 2 | | sorro (nosin, oto.) | Specify | | |
| | | Year or Dates: | | 15.00 | Kitto opocny. | | Specin | , WIIII | |
| | | 16a. | Decedent's Usual (Give kind of work | done during most of | working | 16b. Kind of B | usinass/industry | | |
| | Coilege (1-4or | 5+) | life. DO NOT use | | | | WING COURT | | |
| | eeti | | BOOKKEEP | | Nama (First Middle | | CKING COMPANY | | |
| | | | | | ame (First, Middle, Maiden Surna ETT V | | ANKIRK | | |
| | CAN: | | Malling Address (| | | | | | |
| | 19a, informant's Name/Relations! RONNIE EULDRIC! | | | The second second | | | ty or Town, State, Zip Code) BURNIE, MD. 21061 | | |
| | 20e. Method of Disposition | CANTER (DI | _ | Disposition (Neme | | Deta | | City or Town, State | |
| | 1 ☐ Burial 2 ☐ Cremetion | | cemeter | y, crematory or oth | or niecei | 2/22/2000 | | | |
| | 4 Donation 5 Other (S) | | GLEN I | | ORIAL PARI | () | GLEN BU | RNIE, MD. | |
| | 21. Signature of Fineral Service I | icensee | | | | | | HOME, P.A., | |
| - | Haw BH | agan | - | | | | | E, MD. 21061 | |
| | 23a. Pert1. Enter the disaasa, or shock, or heart failure. List | complications that cause only one cause on each | ed tha daath. Do n line. | ot enter the moda | of dying, such as can | diac or respiratory | arrest, | Approximate Interval Between Onset and Death | |
| | | 10 + | - Care | 2 - 2 - 1 - 2 | lor A | 00.00. | 1 | Chiset and Death | |
| | Immediate Cause (Final diseasa or condition resulting in death) | a. Heur | e cever | NO DES CO | W. A | ce ou | | Ochey | |
| 16 | . Southing in a deating | | Due to (or es a c | onsequence of): | | | | | |
| nine | | b | | | | | | | |
| dical Examiner | Sequentially list conditions, if any, leading to immediate | | Due to (or as a c | onsequence of): | | | | | |
| E E | Cause (Disease or injury | c | | | | | | | |
| | that initiated events resulting in death) Last | | Dua to (or es a c | onsequence of): | | | | | |
| Completed by Physician/Me | | d | | | | | | | |
| clar | | | | | | 1 001 01 | | | |
| nysi | Part II. Other significant condition | , | . 1 | the underlying cer | 1 - | | ~ | ntribute to the cause of death? | |
| Y | Old Ceret | ro veseul | er H | e den | | _ '' | Yes 2 No | 3 Probably 4 Unknown | |
| Q P | | | | | | 24a. Wa | s an autopsy | 24b. Wera autopsy findings | |
| ete | | | | | | perl | ormed? | available prior to completion of cause | |
| du | | | | | | · · · · | of daath? | | |
| | | | | | 1 | Yes 2 No | 1 ☐ Yes 2 ☐ No | | |
| Be | 25. Was case referred to medical axaminer? | Hospital: | | | Other | Death (Check only | | | |
| : To | 1 Yes 2 Nio | 1 Li Inpat | | | Nursin | g Home 5 ☐ Ras | idence 6 Oth | | |
| Log | 1 Naturai 5 ☐ Pendin | | ay Year) Ir | njury M | c. fnjury at Work? 1 ☐ Yes 2 ☐ No | 250. 0050100 | anjury occur | | |
| ca | 3 Sulcide 6 Could n | ot be | niury - At home fee | m, street, factory, | | 28f. Location | (Street and Numi | ber or Rural Route Number, | |
| Certification: | 4 Homicide determine | building, e | tc. (Specify) | , atroot, tactory, | | | оwn, State) | | |
| Ö | 29a. Certifier 12 Certifying | Physician: To the best | of my knowledge | deeth occurred at | the time, date and n | ace, and due to the | cause(s) and m | annar as stated. | |
| edical | | | of axamination and | | | | | and due to the cause(s) | |
| Medical Certifi | 29b. Signature and title of certifier | | | 200 | License number | | 20d Data signs | od (Month, Day, Year) | |

29d. Dete signed (Month, Day, Year)
2-19-2000 29c. License number 29b. Signature and titla of certifier D21684 mae MO

30. Name and address of person who completed ceusa of death (Item 23s) (Type, Print)
C-V-C4RIAC-M-D \$-109 RITCH (B 6WY, PASADENA, MD 21122

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrar's Signatura

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

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Maryorie

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. 05404 State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 27,28a,b,c,d,e,f per me G791 1/10/01 yf 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Kathryn Gallagher February 4:08 PH 15, 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital
7. Age (In yrs. last birthday) Baltimore Samaritan Baltimore If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Yea 7 / 25 / 1944 5. Social Security Number If Under 1 Year 9. Birthpiece (State or Foreign Country)
Illinois **Funeral** Months Days 1□ M 25 F 577-58-1153 55 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show soical Examiner must be notified at Baltimore Director Baltimore 1 ☐ Yes 🏌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6001 Pinehurst Road 21212 U.S.A. Funeral filed within 72 hours efter deeth 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify:White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than ' Iry or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Psychiatric Social Worker Shepard Pratt Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) 86 Edward Gallagher Winifred Malloy 19e. tnforment's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Winnie Koontz 13531 Triadelphia Road Ellicott City, MD. 21042 permit. Pages 1 and Department of Health Important: If Nem 27 eny injury or other transcence. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore/Wash. Crematory 2/18/00 Laurel, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 and computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final Andric disease or condition resulting In death) **Examiner** Due to (or as a consequence of) Examiner by Suicide AHempt burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): physician s the burial P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 98 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. signed by 3 □ Probably 4 □ Unknown Wes 2□ No Manic Depressive Disorder Division of Vital Records, Completed 24b. Were autopsy findings available prior to 24e. Wes an eutopsy performed? completion of cause of death? 2 7 No 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatiely filled in by the funeral director, g Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred subject hanged 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Injury 1 Divatural 5 Pending self 2/8/00 1 Yes 2 No unknown investigation 2 Accident 6 Could not be determined 3√ Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 6001 Pinehurst Ave, 28e. Pleca of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital within 24 hours a To the Funeral Completely filled in Baltimore, MD Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated. 2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 15, 2000 P 13 454 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) LINDA LINGSAY Md. Raven

Blyd

32. Registrar's Signeture

Baltimore

Maryland

21239

State Registrar 31. Date filed (Me

television of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day **Physician** February RUTH HACKER 9:40 A.M. 16,2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Munder 24 Hrs. 8. Data of Birth Month, Day, 1908 Square 7. Age (In yrs. last birthday) tranklin Center Baltimore If Under Months 5. Social Security Number 6. Sex Birthplace (Stata or Foraign Country) Funeral Days 1 M 2 XF 039-12-6700 91 PA Director **Usual Residence of Decedent** the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23s or 28s-f ahow injury or other treumstic event, ma Medical Examinar must be notified at MD Baltimore Essex 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2728 Holly Beach Road 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiens. Important: if item 27 is marked other than "natural", or its important: or other treumatic avent, the Medical Examine BAGS. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: White à 3 NWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry acker, Ruth Elementary/Secondary (0-12) College (1-4or 5+) A.L. Hacker Co. Inc. Accounting 12th 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 8 George Passmore Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2728 Holly Beach Road Baltimore Md. 21221 Robert Hacker / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Donation 5 Other (Specify) Dulaney Valley Cemetery 2/18/2000 Baltimore Md. 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only a recause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner a d 955 attending physicien and for use as the buriel-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Tion Box 68760. certificate be Physician/Medical Due to (or as a consequence of) foration Status Post Colectomy 0 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown emen Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 npetient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

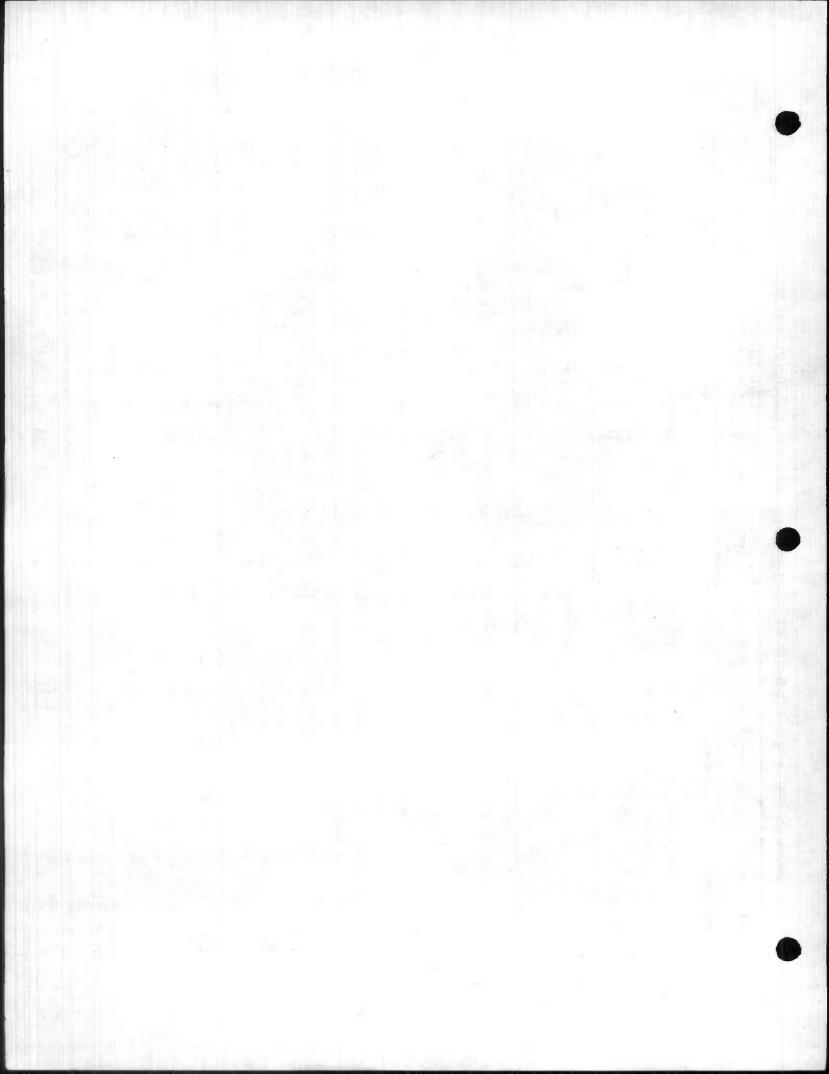
Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) d cause of death (ttem 23a) (Type, Print) Franklin Square Drive Baltimore, MD 21237 am

Registrar

State

22/2/

32. Plot



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05406 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 2000 Month **Physician** Richard E. Harris FEB 16 2:45 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore #Under 24 Hrs. B. Dete of Birth (Month, Day, Year)
JULY 3, 19 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Months Days Yrs. 216-28-1181 69 Director Maryland Usual Residence of Decedent with the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or herna 23a or 28a-f show the Medical Examiner must be notified at MD Harford Bel Air 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 C Van Guard Way 21015 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or he 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Planner Self employed Financial Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be John Harris Beatrice Belle Hollander 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra pince. 21014 200. Place of Disposition (Name of cametery, cremetory or other place)

201. Place of Disposition (Name of cametery, cremetory or other place)

202. Location ? City or Town, State Joan A. Harris/wife 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/17/00 Baltimore, MD 21. Signature of Funeral Service Doepsee 22. Name and Address of Fecility homos Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21228 Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final MESOTHELIOMA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of) Box Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? O 1 Yea 2 No 3 Probably 4 Unknown م Records, should be d p 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 : 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical axaminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)HOSPICE Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Panding investigation A Hospital or Autoria 24 hours after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after der To the Funeral Director completaly filled in by th 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical ŝ 29b. Signature and the of certi 29c. License number 29d. Date signed (Month, Day, Year) 7/00 D43121 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 16 Rev 6/95

State

Registrar

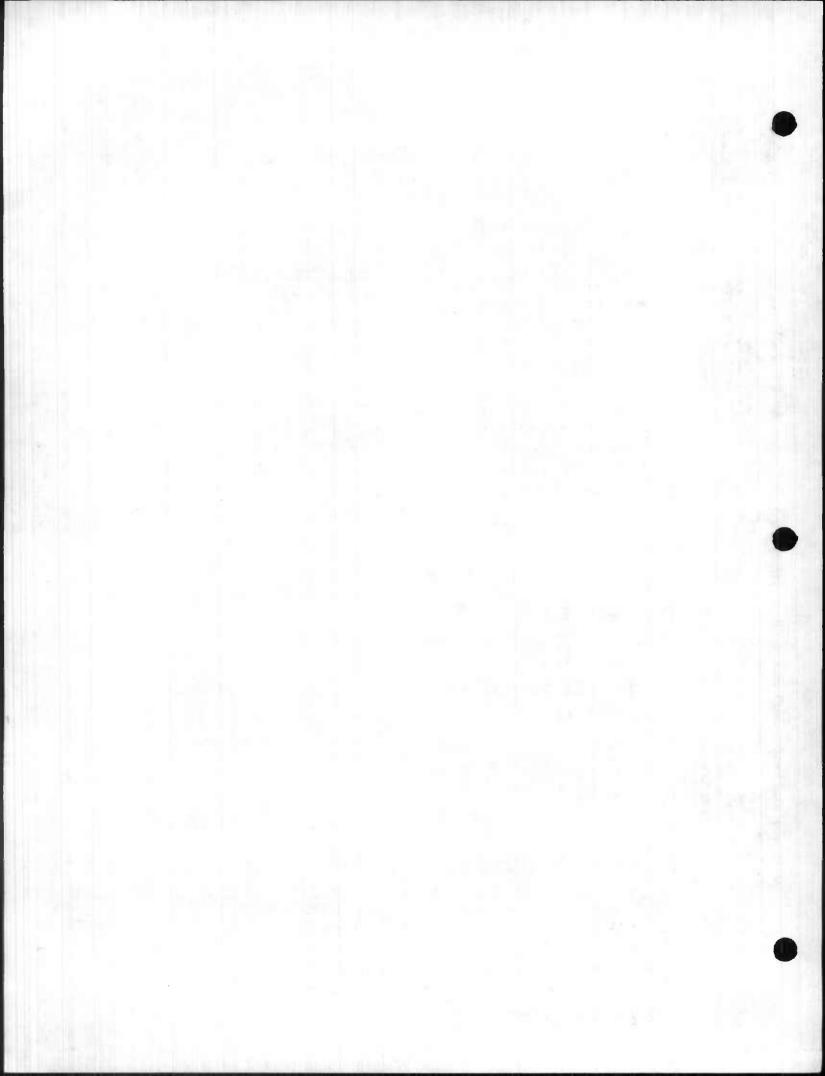
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32. Registrer's Signeture



Registrar

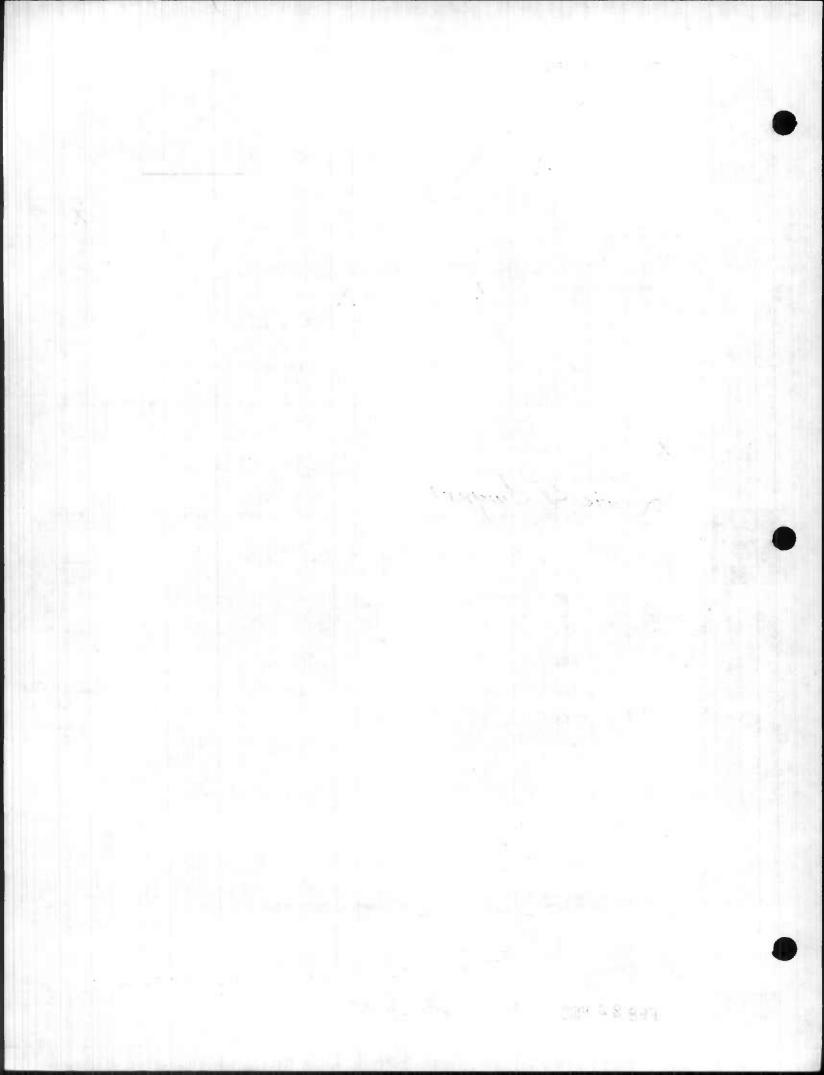
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31. Date filed (Month, Dey, Year) FEB 2 2 2000 111 Penn Street, Baltimore, Maryland 21201

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32. Registrar's Signety



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State of Maryland / Department of Health and Mental Hygienen 05408 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Heck ohn Anthony FEBRUARY 12:45 AM 20, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Deys 164-18-2995 Director S1P1,1918 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nant of Health and Mentel Hyglens.
Int. If them 72 is marked other than "returel", or items 23s or 28s-f show ury or dening 1 a marked other than "returnel", or them so the notified sin ury or other traumatic avent, in Manges Exeminar mast be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2. 21234 Blud her Completed by Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 Ness 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify Specify: WNI +C 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Koppers Co. mechanical Engineer Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony tech Schar Emilie 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse G. Her 8500 Walther Blud-Apt 1212 Baltimore, mo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, State Fa 6 . 24 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MO Evans Funeral Chapel-Beltin 2000 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Baltimore, mp a 23s. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 18 DAYS MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of) Physician/Medical Examiner CORONARY ARTERY DISEASE The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Due to (or es a consequence of): US0 88 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEPSIS Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? this certificata has 2)K) No 1 ☐ Yes 20 No 1 Yes or Attanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attanding with 24 hours after daeth.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ala Wi D41410 n Mrs. MO 30. Name and address of person who completed cause of death (Item 23s) (Type, Print)

State Registrar

JOGINDER

31. Date filed (Month, Day, Year)

P.

2 2 2000

MEHTA

M.D., 7601

32. Registrar's Signature

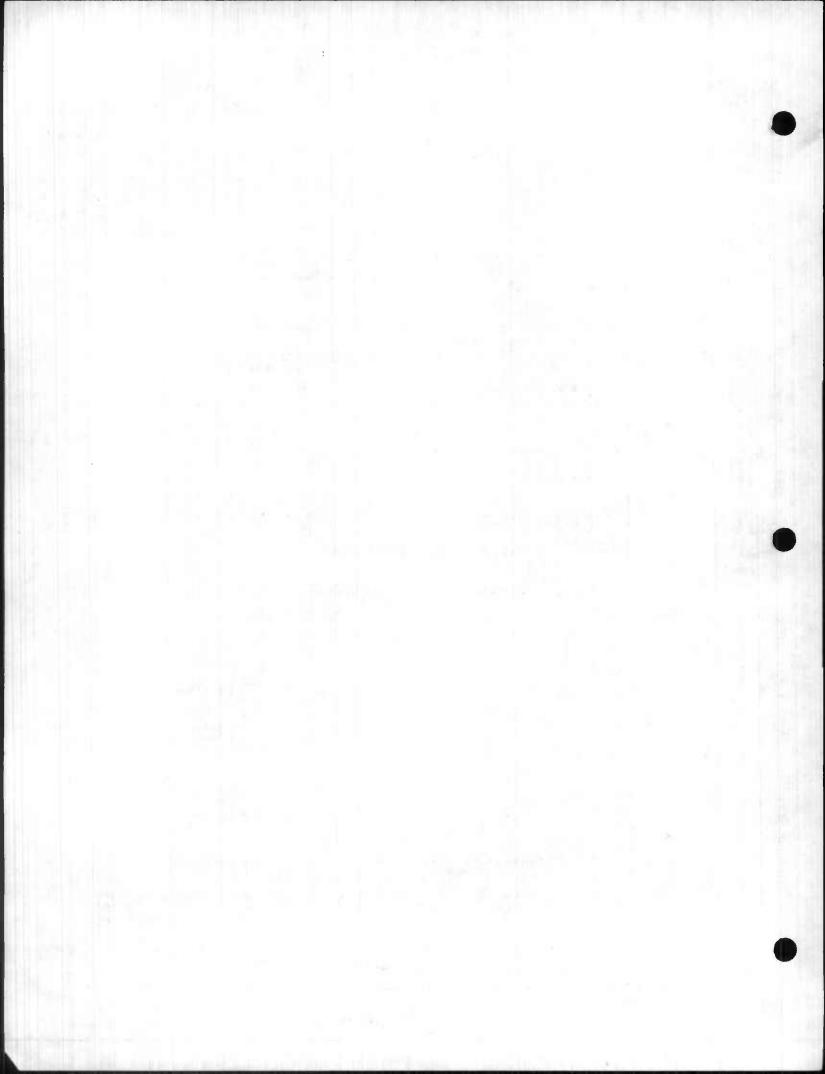
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OSLER DRIVE, TOWSON, MARYLAND

21204



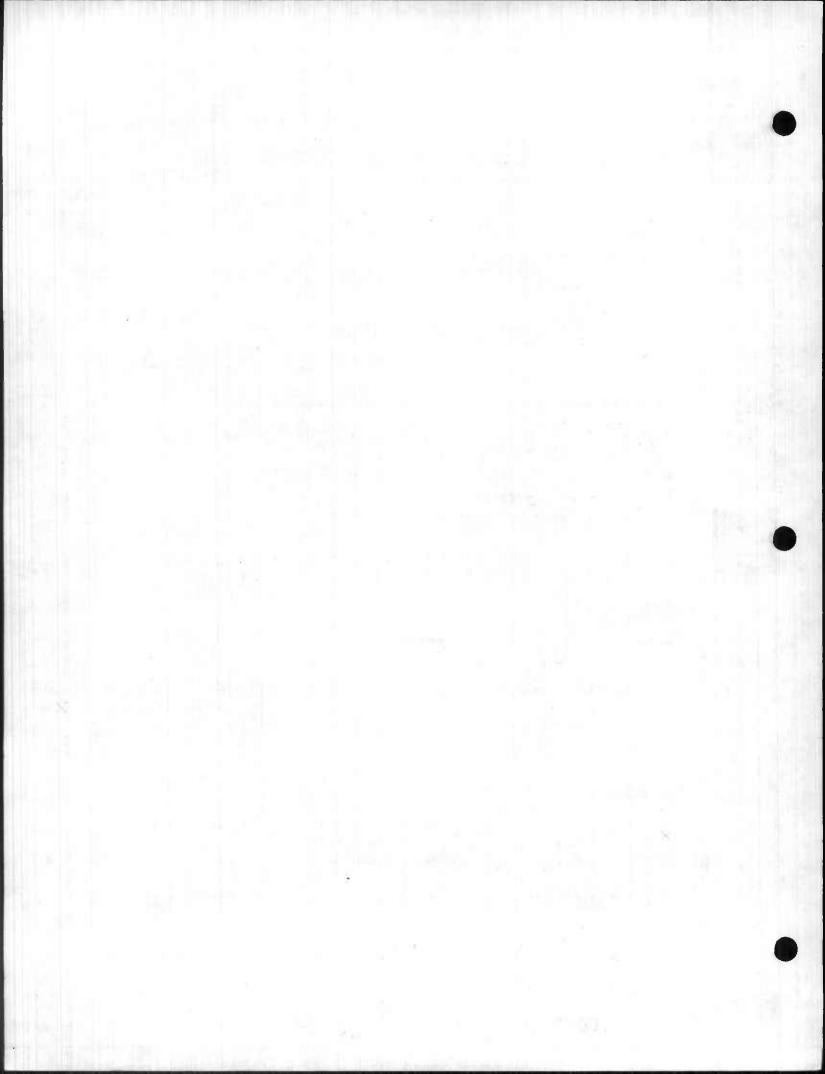
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State of Maryland / Department of Health and Mental Hygieneo

| RANCIS HAWKIN | IS | State of Marylan | | tment of H | | fental Hy | UU | 0 | 5409 | | |
|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------|------------|-------------------------------------------------------------------------|--|--|
| Physician | 1. Decedent's Name (First, Middle, Last) | | 0071 | mouto or | Dodan | 2. Date of De | Reg. No. eath Day | Year | 3. Time of Death | | |
| Physician /Medical | FRANCES C. HAWK | | | | 4b. City, Town, or L | FEBRUA | RY 17, | 2000_ | 15:43 | | |
| Examiner | 342 BLOOM STREET | APARTMENT 2 | | If Under 1 Year | Baltimor | e | N/A | A | | | |
| Funeral Director | 218-18-8663 | 7. Age (In yrs. 7) | | | | Hours Min. 8. Date of Birth (Month, Day, Ye) JUL 14 19 | | | | | |
| anyland | Usuel Residence of Decedent 10e. Stete 10b. County | 10c. City | y, Town or Loca | | | | | 1 | 0d. Inside City Limits XXYes 2 □ No | | |
| with the Manyland a or 28a-f show De modified at | MARYLAND N/A 10e. Street and Number | | BALTIM | ORE CITY 10f. Zip Code | Z | | 10g. Citizen of | What Coun | | | |
| death rms 23 r.m.m. | | APT 210 2. Was Decedent Ever in U, Armed Forces? | S. 13. W | 212 as Decedent of F es, specify Cub | 217 Iispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No Rican, etc.) | U.S.A | e - Americ | | | |
| 15-0020 72 hours elter natural; or its | 3€\$Widowed 4 □ Divorced | 1 ☐ Yes ②(XNo If Yes, Give Yeer or Dates: | | Yes 21XMo | Specify: | | Specif | BLAC | | | |
| | 15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) | ation completed) College (1-4or 5+) | (Give ki | | pation during most of work d) | ing | 16b. Kind of B | | lustry | | |
| and 2 dbe filed mal Hygie ed other it | 17. Father's Name (First, Middle, Last) | | unkno | wn | 18. Mother's Name | | | | | | |
| Maryland d 2 should be file the and Mental Hy treumetic event. | WALTER E. STREAMS MARY ROBINSON 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete | | | | | | | | Code) | | |
| | Louise Paul/Sister 20e. Method of Disposition 1 🖾 Xurial 2 🗆 Cremetion 3 🗆 Re | | lace of Disposit | | | Date | ltimore, 20c. Location | | yland 2121 wn, Stete | | |
| Baltimore, permit. Pages 1 at Department of Hea Important: If Item, any Injury or other once. | 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licenses | CEMETERS | Address of Facility | | | | | | | | |
| 0 88558 | WILLIAM C BROWN COMMUNITY FUNERAL HOM 1206 W NORTH AVENUE 23e. Pert. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| Box 68760, sath certificate be associed effor use as the burial-transit claryMedical Examiner | Cause (Disease or Injury that initiated events resulting in death) Last | Due to (or | teriosclerotic Cardiovascular Disease de to (or as a consequence of): de to (or as a consequence of): de to (or as a consequence of): | | | | | | | | |
| P.O. Box 68 at the death certifical by the ettending platched for use as the physician/Med | d. | | | | | | | | | | |
| | | 23b. Did tobacco use contribute to the cause of dea 1 Yes 2 No 3 Probably 4 Unkn | | | | | | | | | |
| II Records, P The law requires that the has been signed to page 2 should be detered. | 24a. Was an a performe INSPEC | | | | | | | | ere autopsy findings silable prior to mpletion of cause death? | | |
| of Vital I Physicien: The this certificate and director, pages.; To Be Co | 25. Was case referred to medical examiner? | spitet: | FR/Outnationt | 3□ DOA Ott | 26. Place of Deat | h (Check only | | | | | |
| Nivision of Arending Philifer death. Interdect: After this in by the funeral in by the funeral entification: T | | | | | | | | | | | |
| To the Hospital Within 24 hours a To the Funeral i completely filled | | clan: To the best of my known: On the basis of examinat and menner steted. | | | | | | | | | |
| To the company | 29b. Signature and title of certifies | time | M | 29c. Licens | c.M.E. | | 29d. Date signed (Month, Day, Year) FEBRUARY 18, 2000 | | | | |
| φ | 30. Name and agoresis of person who com | pleted cause of death (Item | | int) | Street, | Baltim | | | | | |
| State Registrar | 31. Date filed (Month, Pey, Year) | 32. Registrar's Signal | 200 | - | nka | | | 1 | | | |

DHMH 16 Rev 6/95

ORIGINAL



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3. Time of Death Year **Physician** MARY ELIZABETH HOLLEY 13 2: 40.P.M. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHIMORE CO. AVEN HOME CATONSVILLE Jursina ESI 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1□ M 25 F 93 212-30-6716 Director MAY 12 1906 NORTH CAROLINA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 K Yes 2 □ No BALTIMORE Director MARYLAND 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ð 21237 23a 1307 SCHEELER USA AVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1€ Never Merried 2 Married ò altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK Aq 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) NURSES' AIDE DOCTORS 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be named of Health and Mental? MARY UNKNOWN FENNELL WILLIAM 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRAND BURKE 1307 SCHEELER AVE BALTIMORE, MD 21237 RONALD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from Stete ARBUTUS MEMORIAL PARK FEB 18 BALTIMORE CO, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Neme end Address of Facility NUTTER FUNERAL HONES, TNC

2501 GWYNN FALLS PARKWAY

BALTIMORE, MARYLAND 21216

23e. Part 1. Enter the disease, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel HROM BOSIS disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last pue Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) USB 85 P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yea 2 No signed b Division of Vital Records, PV Completed 24b. Wera autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? certificate 1 ☐ Yes 21 No 1 TYPS 2 THO or Attending Physician: funeral director. 25. Was case reterred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Mennef of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? After 1 ☑ Natural 2 ☐ Accident 5 Panding investigation 1 Yes 2 No To the Hospital or Attendion within 24 hours after death. To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day. Year) 2000 sueeu

5 State

Registrar

31. Date filed (Month, Day, Year)
FEB 2 2 2000

32. Registrary Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21208

MARY

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Certificate of Death

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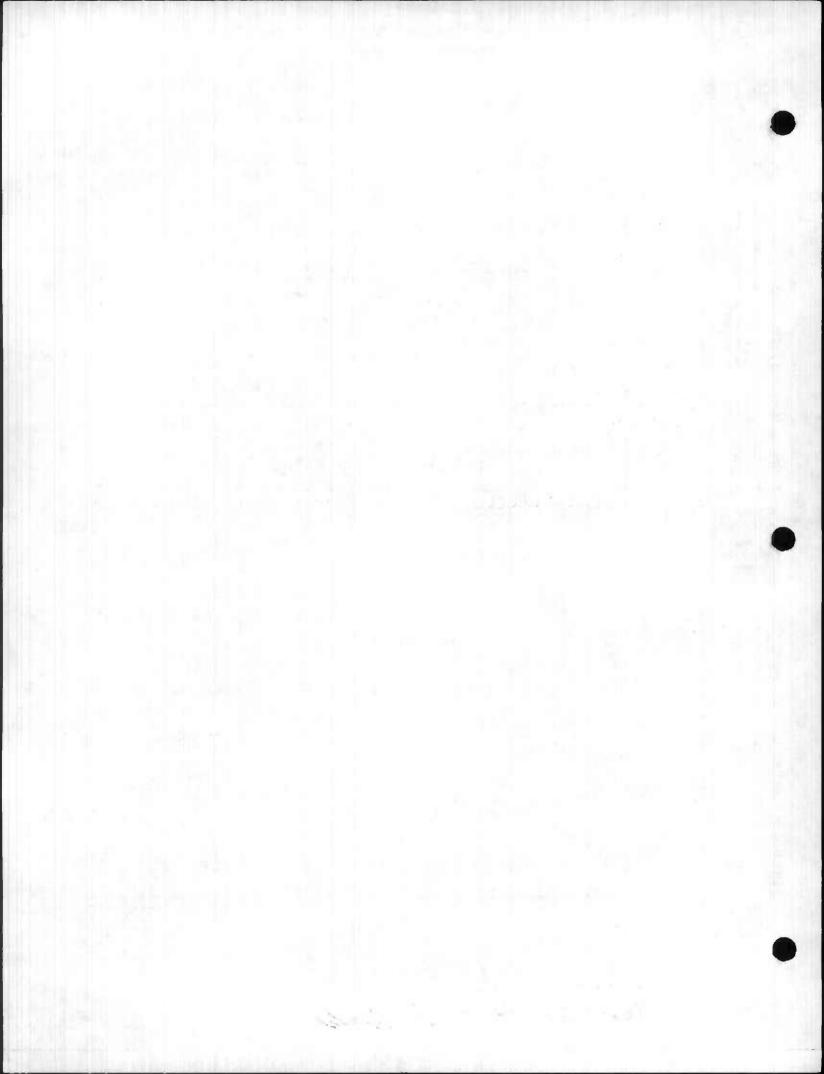
5:00 A.M.

February 18, 2000

John Hinson

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| Stella Maris Hosp | ice | | | | | Timo | | | | Balt | imore | |
| | Sax 1DTM 2□F | 7. Aga (In yrs. | | Months | V 1 Yaar Days | If Under Hours | 24 Hrs. Min. | 8. Data of | Birth , Day, Y | ear) | 9. Birth | piace (Stati |
| 220-42-8444 | TAM ZUF | 53 | Yrs. | | | | | July | 20, | 1946 | Wash | ingto |
| Usuai Rasidanca of Decedant 10a. Stata 10b. County | | 100 CH | ty, Town or | Location | | | | | | | | 40d toolde |
| Toa. Stata 100. County | | 100. 01 | iy, town or | Location | | | | | | | | 10d. tnside |
| Maryland Harfor | rd | Ab | ingdo | | | | | | | | | |
| 10e. Street and Number | | | | 10f. Zi | p Code | | | | 100 | . Citizen of | f What Cou | intry? |
| 354 Butterfield I | _ | | | | 1009 | | | | | .S.A. | | |
| 11. Maritai Status | Armed Fo | | I,S. 13 | 3. Was Deca If Yas, spe | edent of H ecity Cubi | lispanic Ori an, Mexicar | gin? (Sp i, Puarto | ecify Yas o Rican, atc. | r No- | | ace - Amari ack, Whita | ican indian, , etc. |
| 1 Nevar Married 2 Married | 1 Yas | 2 □ No va | | 1 🗆 Yes | 2 No | Specify: | | | | Speci | ity: | |
| 3 Widowed 4 Divorced | | Datas: 1966 | | | | | | | 1.0 | | | ite |
| 15. Decedant's E (Specify only highast gr | ducetion ada completed) | | (Gi | cedent's Usu iva kind of wo | ork done | during mos | t of work | ing | 16 | b. Kind of I | Business/Ir | ndustry |
| Elemantary/Secondary (0-12) | Coilega (| 1-4or 5+) | 111100 | DO NOT | | | | | | | 1 0 | |
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| | i) | | | | | | | | | iueri suma | arriet/ | |
| Homer M. Hinson | | | | | 1 | | | s Spic | | | | |
| 19e. Informant's Name/Relationship | | | | ailing Addres | | | | | | | | ip Code) |
| Janet Hinson (Wif | e) | | | 4 But | | ield l | rive | - | | | | 21009 |
| 20a. Mathod of Disposition 1 X Buriai 2 ☐ Cremation 3 [| Ramovai from | | | sposition (Na crematory or | | ce) | | Data | 20 | c. Location | - City or T | own, State |
| 4 Donation 5 Other (Speci | | | dowri | dge Me | em. I | Park | | 2/21/0 | 00 | ELKRI | DGEe. | Mary |
| 21. Signatura of Funarai Sarvice Lice | nsae. | | | 22. Nama a | nd Addre | ss of Facilit | У | | | | | |
| DRum GIL | 1.000, | | | Schim | | | | | | | - | |
| 23a. Part1. Entar tha disaasa, or con | polications that | <u> </u> | | DIU W. | _ Ma(| rnaı. | L KO | ad, | peT . | Air, M | ID Z | 1014 |
| shock, or heart failure. List only immediate Causa (Final disease or condition resulting in death) | ona cause on a | L CELL | CANCE | enter the mo | de of dyin | | cardiac | | | 1, | | Approxin |
| immediate Causa (Final disassa or condition rasulting in death) | ona cause on a | L CELL (| CANCEI | enter the mo | de of dyin | | cardiac (| | | 1, | | Approximintarvei f |
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PATRICK W. HAGERTY, SR. February 19,2000 03:36pm /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Yeer | Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 100 M 2□ F Hours Director 216-32-4891 63 MARYLAND Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits rai", or items 23s or 28s-f show Examiner must be notified at 1 XYas 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 912 S. DECKER AVENUE U.S.A. 21224 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 DAYes 2 □ No If Yes, Give Yeer or Detes: 1954–58 Waa Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Status Pages 1 and 2 ahould be filed within 72 hours after or and of Healith and Mental Hygiene. ant: If item 27 is marked other than "natural", or her uny or other traumate event, its Mental Enter in ury or other traumate event, its Mental Enter in ury or other traumate event, its Mental Enter in ury or other traumate event, its Mental Enter in ury or other traumate event, its Mental Enter in ury or other traumate event, its Mental Enter in ury enter its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and its Mental Enter in unit and i 1 ☐ Never Married XX Married 1 Yes 20 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) POLICE OFFICER BALTIMORE CITY 17. Fether'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be WILLIAM JOSEPH HAGERTY MARGARET RITTERBUSCH 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tr JOAN HAGERTY/ WIFE 912 S. DECKER AVENUE, BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removel from Stete **Department** 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST V.A. CEM! 2/25/00 REISTERSTOWN, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the deeth certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or es e consequence of): P.0. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yea 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be

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of Vital Division

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1 Yes 2 No

27. Menner of Death

Netural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier lan anson

29c. License number MP

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) 00 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (fem 23a) (Type, Print)

Hospitel:

Tianrong Jiang, M.D. 6701 N. Charles Street, Towson, Maryland 21204

1 NInpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

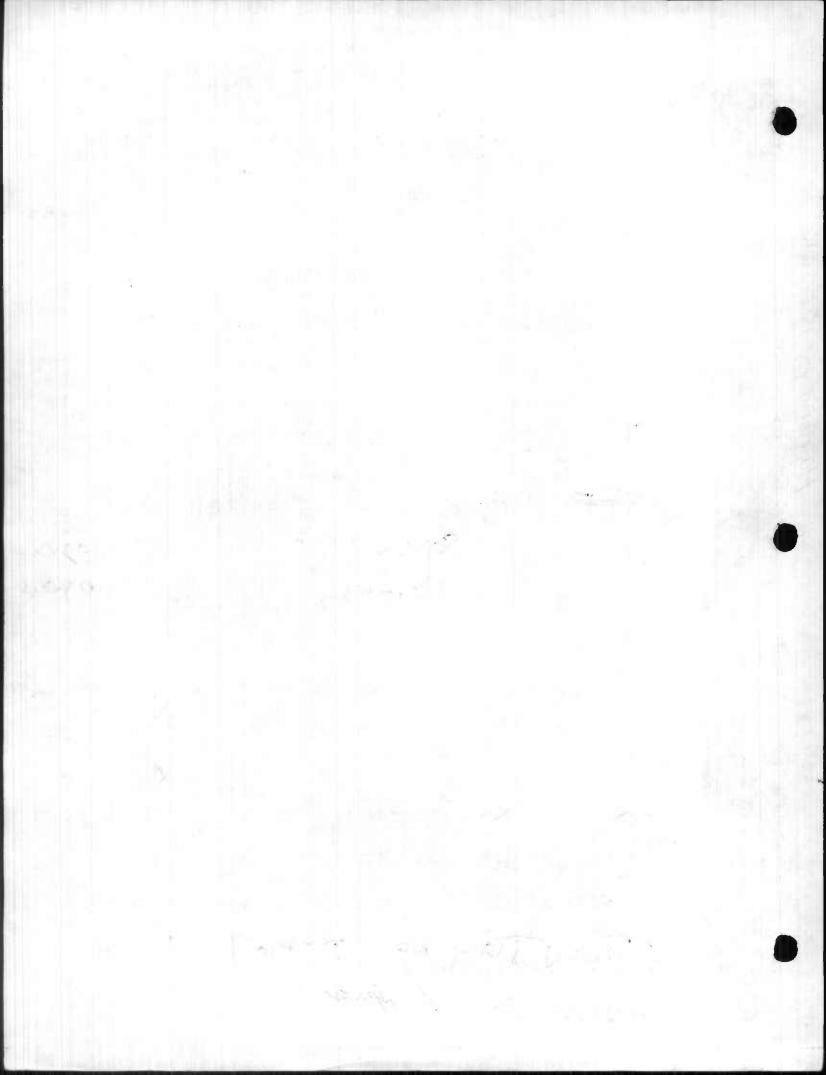
28b. Time of Injury

31. Date filed (Month, Day, Year) 37. Registrare Signature

5 Pending investigation

6 Could not be determined

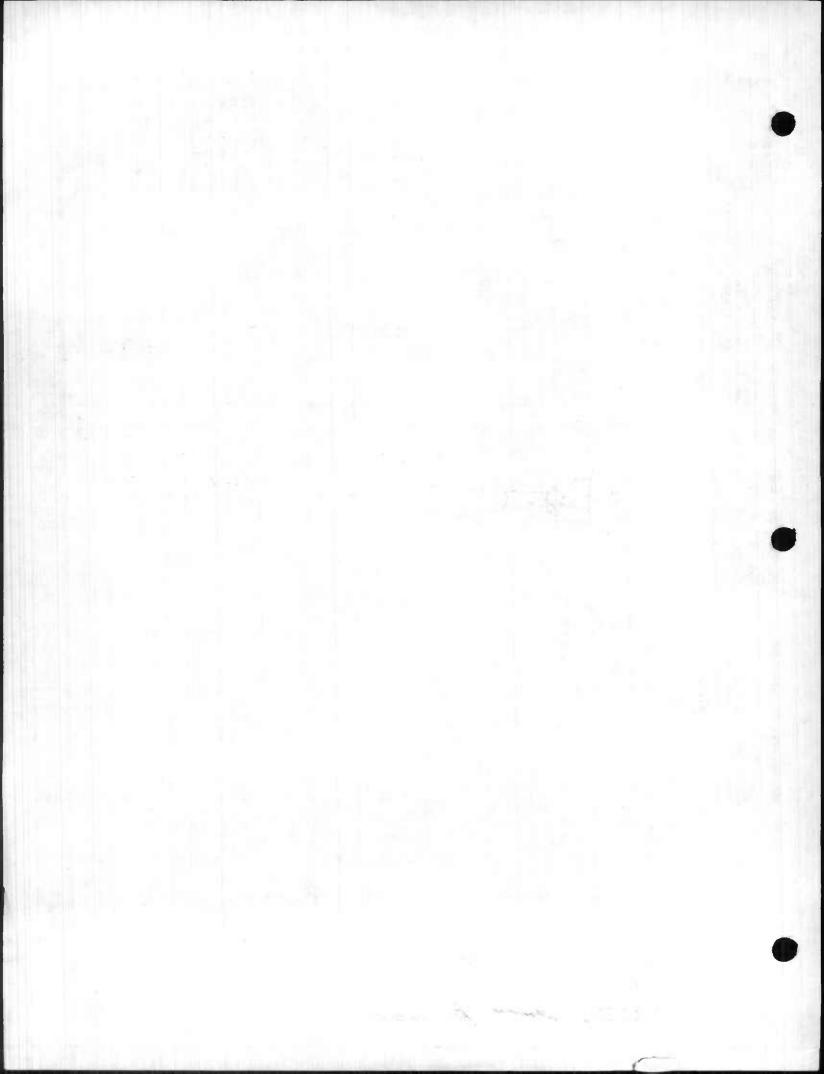
FEB 2 2 2000



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State of Maryland / Department of Health and Mental Hygiene 0 05413

| | | | C | ertificate | e of | Death | | | Reg. No. | U | 0410 | | |
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| | 1. Decedent's Neme (First, Middle, L | est) | | | | | | 2. Dete of De Month | ath Dey | Year | 3. Time of Death | | |
| Physician /Medical | MARGARET | MARY | | | F | HOOK | | FEBRUA | RY 17, 2 | 2000 | 12:30 P | | |
| Examiner | 4a Facility Neme (If not institution, gr | ve street and number) | | | 4 | b. City, To | wn, or L | ocation of Deat | 4c. County | of Deeth | | | |
| | Chesapeake Hosp | ice House | | | | Linth | icum | Height | s Anne | Arun | ndel | | |
| Funeral Director | | Sex 7. Age (1 ☐ M 2 🖫 F | In yrs. last birthde 80 Yrs. | y) If Under Months | 1 Year Deys | If Under Hours | 24 Hrs. Min. | 8. Dete of Bir (Month, De NoV • I4 | th Year 919 | 9. Birthp Cour Mary | olece (Stete or Foreign | | |
| | Usuel Residence of Decedent | | | | | | | | | | | | |
| how how | 10a. State 10b. County | 1 | Oc. City, Town or | Location | | | | | 1 ☐ Yes 2☐No | | | | |
| oto oto | Maryland Anne A | rundel | Linth | Linthicum | | | | | | | | | |
| Na or 28s-fs to notified | 10e. Street and Number 405 Sycamore Road | d | | 10f. Zip | 210 | 90 | | | 10g. Citizen of \ | | J.S.A. | | |
| within 72 hours after death with the Maryland ene. Than 'netural', or itema 23e or 28e-f show the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be notified at | 11. Meritei Stetus 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give A Year or Detes: | er in U,S. 13 | n U,S. 13. Was Decedent of Hispanic Origin? (S) It Yes, specify Cuben, Mexican, Puerto | | | | | 14. Rec Bied Specify | ck, White, Wh | | | |
| yglene. The Madel Early, Completed by | 15. Decedent's E | | 16a. Dec | cedent's Usue | Occup | ation | t of word | ina | 16b. Kind of B | usiness/înc | dustry | | |
| C = 0 | (Specify only highest gi | College (1-4or 5+) | life | ve kind of work . DO NOT us | | | it or work | ang | | | | | |
| Comp | 12 | | | Recep | tio | nist | | | Opt | ometr | rist Office | | |
| c aver | 17. Father's Name (First, Middle, Las Angelo Po | • | | | | | | | ne (First, Middle, Maiden Sumame) e Virginia Fletcher | | | | |
| | 19e. tnforment's Name/Relationship | (Type, Print) | 19b. Ma | iling Address | (Street | end Numb | er or Rui | ral Route Numb | er, City or Town, | State, Zip | Code) | | |
| 27 le m r treum | Mrs. Jean Fotia | dis | 164 | Locke | rbi | e Lan | e M | looresvi | lle, NC | 2811 | 1.5 | | |
| r other tr | 20a. Method of Disposition | | 20b. Plece of Dis | | e of | | | Date | 20c. Location - | | | | |
| | 1X Burial 2 □ Cremetion 3 I 4 □ Donation 5 □ Other (Spec | fy) | Cedar H | Hill Ce | met | ery | 1 | 2-19 | | | ark, MD | | |
| Important: I eny Injury o | 21. Signature of Funeral Service Lice | nsee | | 22. Name end | Addre | ss of Fecili | SINC E, S. | GLETON I | FUNERAL EN BURNI | HOME E, MI | , P.A., D. 21061 | | |
| | 23a. Part1. Emblished county, or conshock, on the life beauty of the constant of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the c | iplications that caused the one cause on each line. | e deeth. Do not e | enter the mode | of dyin | g, such as | cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death | | |
| sician edical | Immediate Cause (Final | Ma- | Lade | 1 | C . | | _ (| - A | 0 - | ! | 4 m 0 5 | | |
| miner | disease or condition resulting in death) | a. | ue to (or as a cons | equience of): | C | 10. | 8 | Canc | 40 | 1 | 10105 | | |
| Je Je | | | | | | Ca | | | | 1 | 17mas | | |
| in and tal-transit Examiner | Sequentially list conditions, | b. — Du | e to (or es e cons | | | _ 40 | 11041 | 1 | | | 1 10.10 | | |
| physician and as the burlatransit edical Examir | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents | C | e to (or as a cons | equence of): | | | | | | | | | |
| Die X | resulting in death) Last | d | | | | | | | | | | | |
| for for | Pert II. Other algnificant conditions | contributing to death but r | not resulting in the | underlying ca | use div | en in Pert | 1 | 23b. Dtd | tobacco use co | ntributa ti | o the cause of death? | | |
| ed by the ettend deteched for us / Physician/ | | | | unconjung co | uoo gii | 011 111 011 | | 10 | 1 | | bably 4 Unknown | | |
| should be | | | | | | | | | an autopsy ormed? | 80 | ere autopsy findings ailable prior to empletion of cause death? | | |
| page 2 | | | | | | | | 10 | Yes 2 No | 1[| Yas 2 No | | |
| # 0 W | 25. Was case reterred to medical | | | | | 26. Place | e of Deat | th (Check only o | | Chose | 10000 | | |
| If direct | axaminer? 1 ☐ Yes 2 € No | Hospitel: | 2 ER/Outpeti | ient 3 DO. | A Oth | or. | | oma 5 Rasi | | ner (Specif | NI HOUND TONG | | |
| Atter the funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral fune | 27. Manner of Death 1 Description 5 Pending investigation | 28a. Date of Injury (Month, Day Y | 28b. Time | ot 28 | Bc. Injur Wor | | | | how injury occur | | " Toylor Tox | | |
| within 24 hours after death. To the Funeral Director: After toomplately filled in by the funer. Medical Certification: | 2 Accident Investigetic 3 Suicide 6 Could not I 4 Homicide determined | OD Disco of lains | | street, fectory, | | | | 28t. Location (City or To | Street end Numl wn, Stete) | ber or Rura | al Route Number, | | |
| Funer stely fill dical | 29e. Certifier (Check only one) Certifying Pl | nystcian: To the best of n miner: On the besis of ex and manner state | aminetion end/or | ath occurred a investigation, | t the tin | ne, date er pinion, des | nd place, ath occur | and due to the red at the time, | cause(s) and madate end piece, | anner as s | stated. o the cause(s) | | |
| within To the comple | 29b. Signature and title of certifier | and marker states | 1 | 29c. | Licens | e number | | | 29d. Date signe | d (Month, | Dey, Year) | | |
| 1 | 1/ /wards | MA | Leven | | 0 | 315 | ~ | 1 | Fehru | gry | 17,2000 | | |
| 0 | 30 Name and address of person who | completed cause of deet | th (Item 23a) (Typ | e, Print) | Ц. | ali | | 7/1/12 | (11 | | 0.12011 | | |
| State | 31 Date tiled (Month, Dey, Year) | 32. Registrer's | Signeture | (4)0 | 11 | y) Na | 1) | 7(600) | Oftob | 11 VIE | 1.4. 1/06/ | | |
| Registrar | FEB 2 2 2000 | General 1 | 9. doa | exal | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) 05614 Certificate of Death 2. Date of Death 1. Decedenf's Nama (First, Middle, Last) 3. Time of Death Day HENTZ MAN 06 15 AM LOIS FEBRUARY 19 ZOOU 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State of Birth | 1. Sept. 21,1935 | 9. Birthplace (State 12AN PALLSTOWN BALTIMORE 5. Social Security Number 6. Sex 9. Birthplace (Stata or Foreign 1 M 20 F 229-42-7951 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Randallstown 1 Yas 20 No 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 3838 Brownhill Road 21133 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 1 4s 2 10 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Naver Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Office Supervisor Bakery 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gid Burnett Minnie Byers 19a. Informant's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3838 Brownhill Rd., Randallstown, Md. 21133 Fred W. Hentzman, Jr. - Husband 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Ramoval from State Evergreen Mem. Gardens Feb. 23, 2000 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Puneral Service Licenses Eckhardt Funeral Chapel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Md. 21117 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) HOLANGITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ♣ Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yaa 2000 26. Place of Death (Check only one)

Physician /Medical Examiner

mportant: if lism 27 my injury or other to

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Berns 23a

'natural', or

Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H ant: If lless 27 is marked oth

72 hours after

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

of Vital

Division

Director

Funeral

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Completed

Be

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Examine Physician/Medical Certification: To Be

 Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifical eleisy filled in by the funeral director, To the Hosp within 24 hos To the Fune

Registrar **DHMH 16 Ray 6/95**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 25. Was case rafarred to medical axaminer? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 27 Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number FEBRUARY 19, 2000 1) 37333

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ALTO. MD 21133 MP, NHC

31. Date filed (Month, Day, Year)

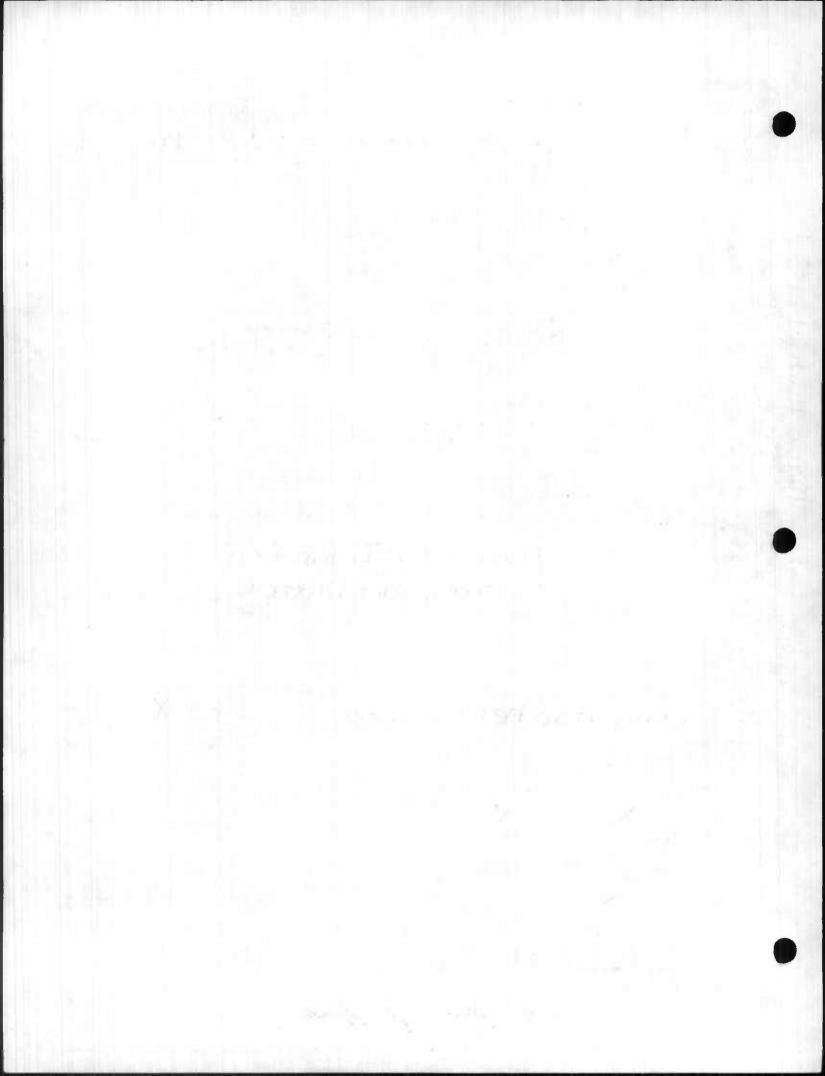
32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** 4:50pm Marie Elizabeth Hudnet February 182000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4e. County of Death **Examiner** pasedale Hospital Center
7. Age (In yra last birthday) | Munder 1 V 6. Sex Itimore tranklin If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2X F Director 218-14-0654 21, 1913 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2K No Essex Director 28a-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 23a 1000 Franklin Avenue, Apt. 1217 21221 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married ò 1 ☐ Yes 2 DkNo Specify: Specify: þ 3℃Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Clothing Manufacturer 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be need of Health and Mental Frederick Ravadge Annie Hoehn 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) of Health at It from 27 is Elaine Hudnet (daughterinlaw) 281 Montrose Avenue, Baltimore, Maryland 21221 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ØBuriel 2 ☐ Cremation 3 ☐ Removal from State 2/21/2000 Baltimore, Maryland Parkwood 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. The the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ock, or heart fallure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 5 Day disease or condition resulting in death) Examiner Examiner be executed **burial-transit** Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760, physician Physician/Medical the Due to (or as a consequence of): The lew requires that the death certificate USB 68 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.0. 2 No à 3 Probably 4 Unknown 1 Yes been signed to should be det Records, by 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending efter death. 1 ☐ Yas 2 ☐ No investigation 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours o Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Certifier edical **Sompletely** (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OL 30. Name and address of person who co se of death (Item 23a) (Type, Print) M. Khan 9000 Franklin Source Baltinula, Manyland Dr. Jahangir Drive, 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 2 2000 Registrar

ORIGINAL

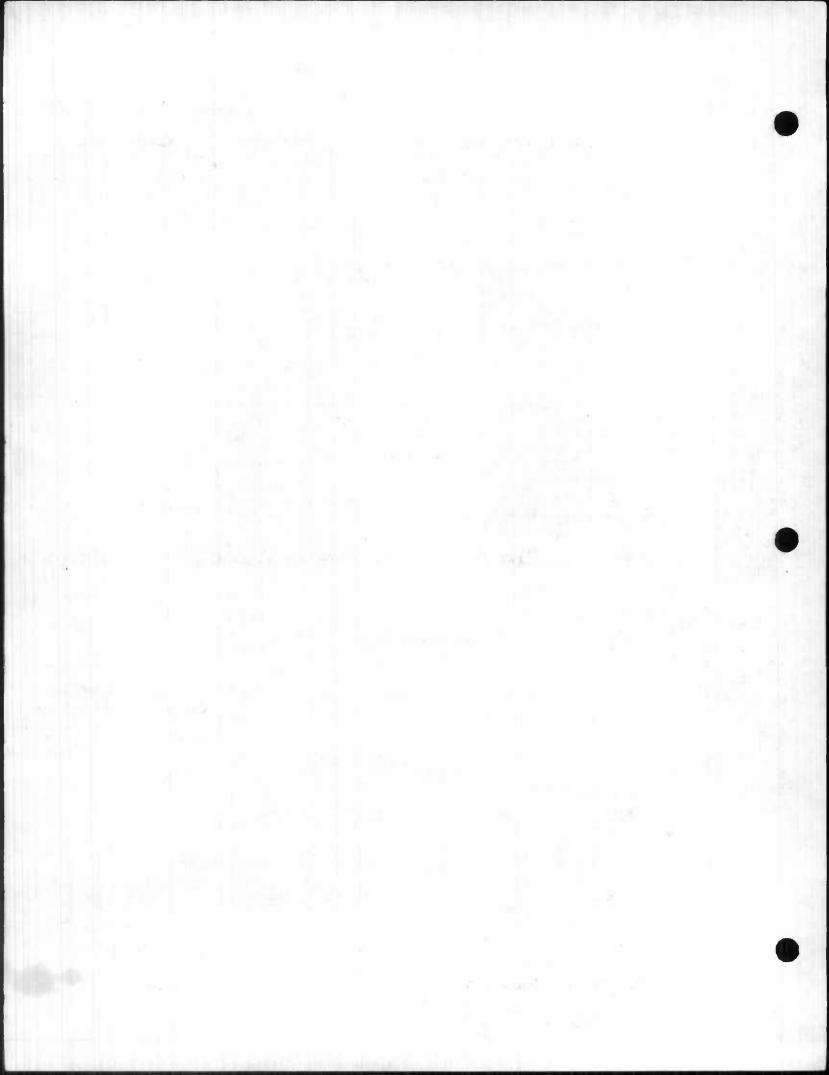


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Ward Hammond , Sr. February 19 2000 cation of Death 4c. County of Death 4:08 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Square Hospital Center In Age (In yrs. last birthday) Franklin Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 2□ F 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral Months Days Hours 247-32-2088 Director May 29, 1927 South Carolina Usual Residence of Decedent the Meryland 10b County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked other than "natural", or hams 23a or 28a-f show traumatic event, the Medical Example must be notified at 1 Tyes 2X No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Wilbur Road 21221 U.S.A.

14. Race - American Indian, Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/2/No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental hygiene. Important: if hem 27 ie marked other than "natural", or that any injury or other traumatic event, the lead of a man 1 ☐ Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lammond, John Painter Hospital Maintenance 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) John Hammond Emma Stroud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Bernice Hammond (wife) 3 Wilbur Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method ol Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Dulaney Valley Mem. Gardens 2/23/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory airest. Mary Land 21221 shock, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical · Chronic Obstructive Pulmonary Disease 10 Years Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): P.0. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 XYaa 2 No 3 Probably 4 Unknown Records. 2 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 Yes 1 Yes 2 No Division of Vitai Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending investigation To the Hospital or Attending within 24 hours effect death.

To the Funeral Director; After completely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Place of tnjury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 Homicide 12. Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) JAN KIM, MD RD 19886 February 19, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9000 Franklin Square Drive Baltimore, Maryland 21237 Kim. 31. Date liled (Month, Day, Year) 32. Registrar's State FEB 22 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05417. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 2:34AM February Grace Adaline Iden 14 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 18, 1924 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1□M 2X0F 220-28-8323 MD Usual Residence of Deceden 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Fairview Drive 21750 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tl Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Dennis R. Snyder Elizabeth Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Due to (or as a consequence of):

Due to (or es a consequence of):

Due to (or es a consequence of):

ENTRAL

Stone Bridge Cemetery

5620 Thompson Road Needmore, PA 17238

141 W.Main St. Hancock, MD 21750-0368

INFECTION

26. Place of Deeth (Check only one)

22. Name end Address of Facility
Grove Funeral Home, P.A.

SEPTICEMIA 2° URUSEPSIS

LINE

Baltimore, Maryland Pages 1 and 2 should be fit iment of Health and Mental H tent: If Item 27 is marked off jury or other traumatic aver Important: If It any injury or **Physician** /Medical

Physician

/Medical

Examiner

10e State

MD

Louise Trail/Daughter

□Donation 5 □Other (Specify)

1. Signature of Funeral Service Licens

1 Burial 2 Cremetion 3 Removel from State

20a. Method of Disposition

Director

Funeral

þ

Completed

Funeral

Director

288-1

8

the Medical Exams

Examiner

Box 68760,

P.O.

Division of Vitai Records,

Hospital

\$

lician and buriai-transit physician the buria for use this funeral After

Physician/Medical by Completed

Examiner

The law requires that the death certificate be axecuted or Attending Physician:

Certification: To Be

completely within 2 Registrar

DHMH 16 Rev 6/95

State

edical 29a. Certifier 29b. Signature and title of certifier

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

BLATERAL LING INFILTRATES—CTIOLOGY GIANTI CEU

PROSTHETIC 25. Was case referred to medical examiner? 1□ Yes 2NNo 27. Manner of Death

2 Accident

3 Suicide

4 Homicide

(Check only one)

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

ARTERITIS

ADRILL

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Lu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one-cause on each line.

> Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

24a. Wes an eutopsy performed?

1 Yes 2 No

sted 2 - MD

Dener

252055 St. HANCOCK, mD 21750

29c. License number

29d. Dete signed (Month, Day, Year)

20c. Location - City or Town, State

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Approximate Intervel Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

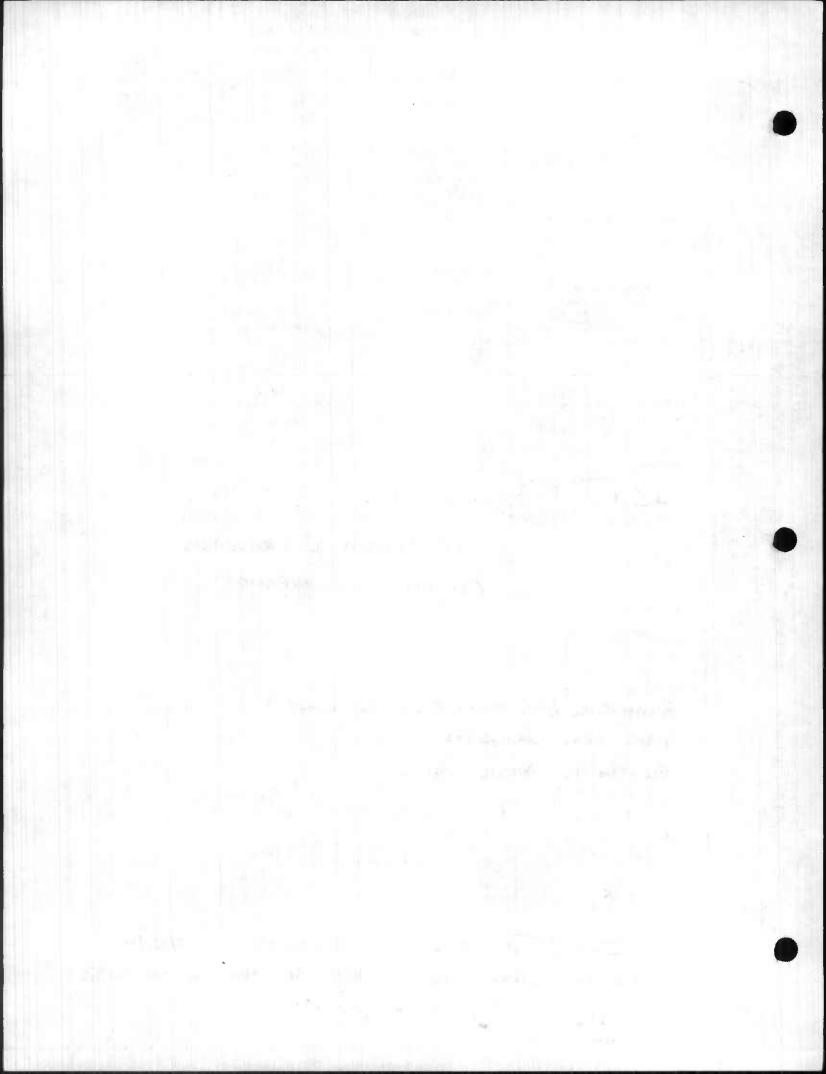
2/16/2000 Hancock, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZVB A172 M · SYED 130 W 130

1416H 32. Registrar's Signature

31. Date filed (Month, Day, Year) FEB 2 2 2000

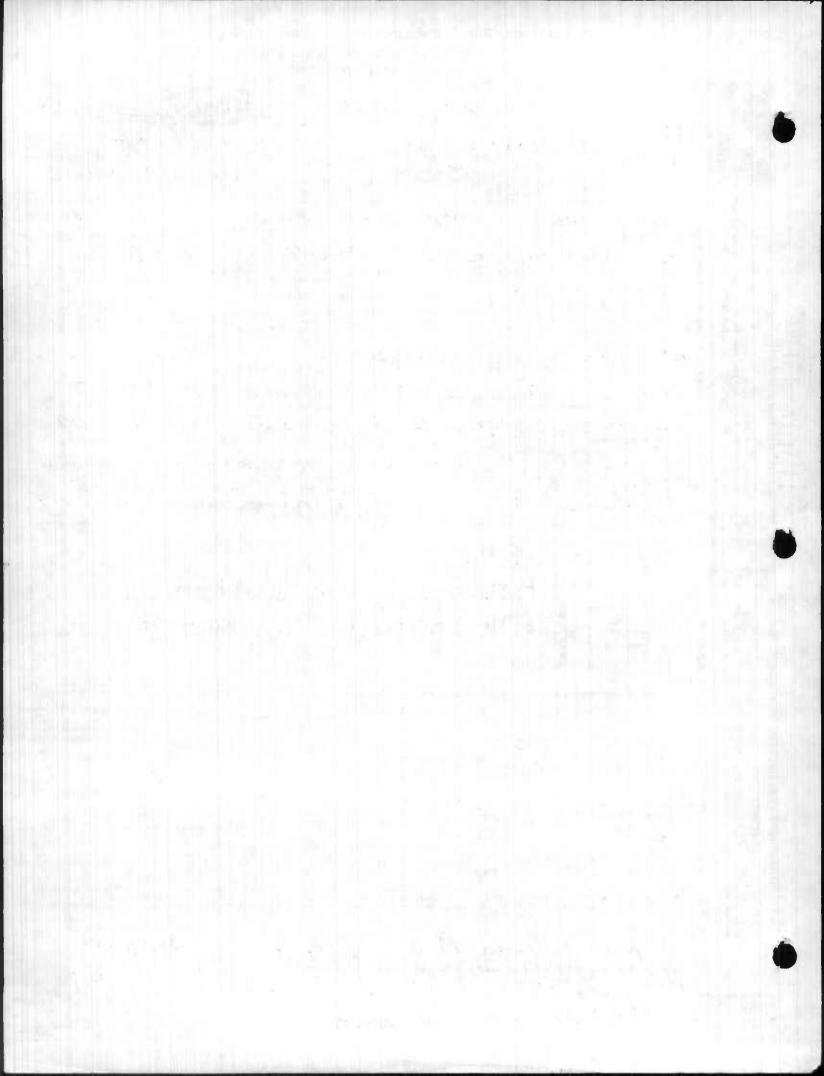


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JONES HOMAS ANTHONY /Medical Ad. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give-street and number) Examiner BALTIMORE NA 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2□ F 217-18-5292 JUNE 24, 1924 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inalde City Limits r than "natural", or leams 23s or 28s-t show the Medical Examiner must be notified at 1 Yes 2 □ No NIA BALTIMORE Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 2601 MADISON AVENUE U.S.A Funeral 14. Race - Americen Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Wss Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, Whita, etc. 1 X Yes 2 □ No If Yes, Give Year or Datea: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: BLACK À 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) LABORER 12TH GRADE MOVING AND STORAGE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Mental JAMES SONES WEST To EMMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 Pitcher St., Baltimore, MD (BROTHER) 21217 Separtment of Health reportant: If New 27 WILLIAM JONES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State ò CARRISON FOREST CEMETERY DA-35-2000 OWINGS MILLS, MID 4 CIDonati 5 ☐ Other /Specify) of Fulperal Service Line 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVEYBALTIMORE, MD 21217 23a. Part1. Enter the disesse, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner leural Effusion Examin bunel-transit Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last pue Box 68760 physician 8 Physician/Medical the 98 use for 23b. Did tobacco use contribute to the causs of peath? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 0 4 Unknown 1 Yes 2 No 3 Probably signed t þ Division of Vital Records. 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? hes page 2 2 No 1 Tes 1 Yea 2 No 25. Was cese referred to medicel examiner? 8 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dimpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury st Work? After 5 Pending Investigation J or Attending safter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital 1 Cartifying Physicisn: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) and mainle. So seems 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier 29c. License number 00 Dalsava 30) Name and siddress of person who completed ceuse of death (them 20a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

DHMH 16 Rsv 6/95

Registrar

2000



Plant A Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) 05419 Certificate of Death 2. Date of Death 1. Decedent'a Neme (First, Middle, Last) 3. Time of Death Month 9:22 am Ellen н. Janney February 11, 2000 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3408 Copley Road Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Jan. 16, 1908 5. Social Security Number If Under 1 Yes 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1□ M 2□ F Mary land 92 213-03-3664 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Baltimore City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 United States 3408 Copley Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, atc. 11. Meritel Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking Bank Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha McGill Emory G. Helm 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Delrey Avenue, Catonsville, MD 21228 Elizabeth J. Allen/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place)
Loudon Park Cemetery 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2/14/00 Baltimore, Maryland 22. Name and Address of Facility
Loudon Park Funeral Home, 3620 Wilkens Avenue 21. Signature of Funerel Serviced Licens Baltimore, Maryland 21229

Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediete Cause (Final mer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Bother (Specify Strup home 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 SNeturei 5 Pending 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29e. Certifier

Examiner the death certificate be executed P.O. Box 68760 Records, Division of Vital Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

b

Norms 23a

"natural", or

Hygiene.

permit. Pages 1 and 2 about be filed w
Department of Health and Mental Hyglen
Important: if Item 27 is merical other tha
any Injury or other traumatic active tha

Physician /Medical

attending physician and for use as the burial-transit

signed by t

should I

certificate

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

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(Check only

Frederick Rd

2 2 2000

2000

Certification: To Sign Sign Affer To the Hospital or Attendir Within 84-hobrs after death. Ye the Funeral Director: A constantly Illed in by the fi desth. 29b. Signature a State

Registrar

32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

Suite 110,

OBURN

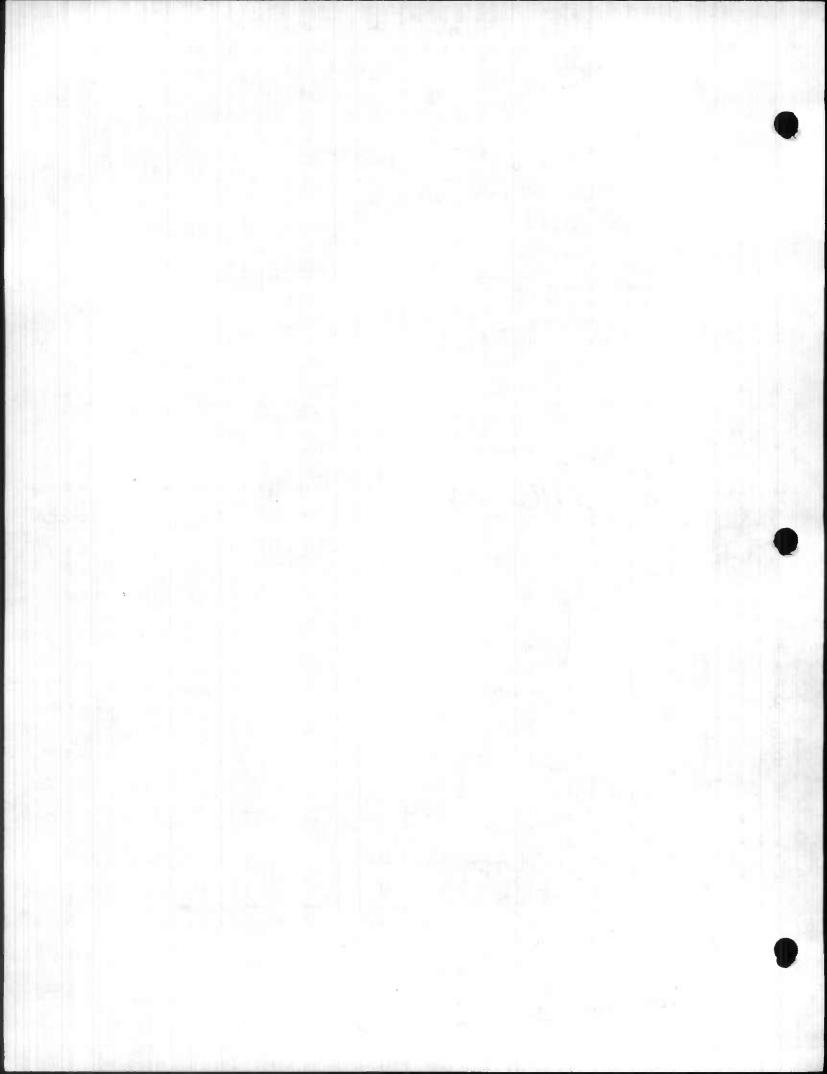
Catarorde

29c. License number

30185

29d. Date signed (Month, Day, Year)

Feb 11, 2000

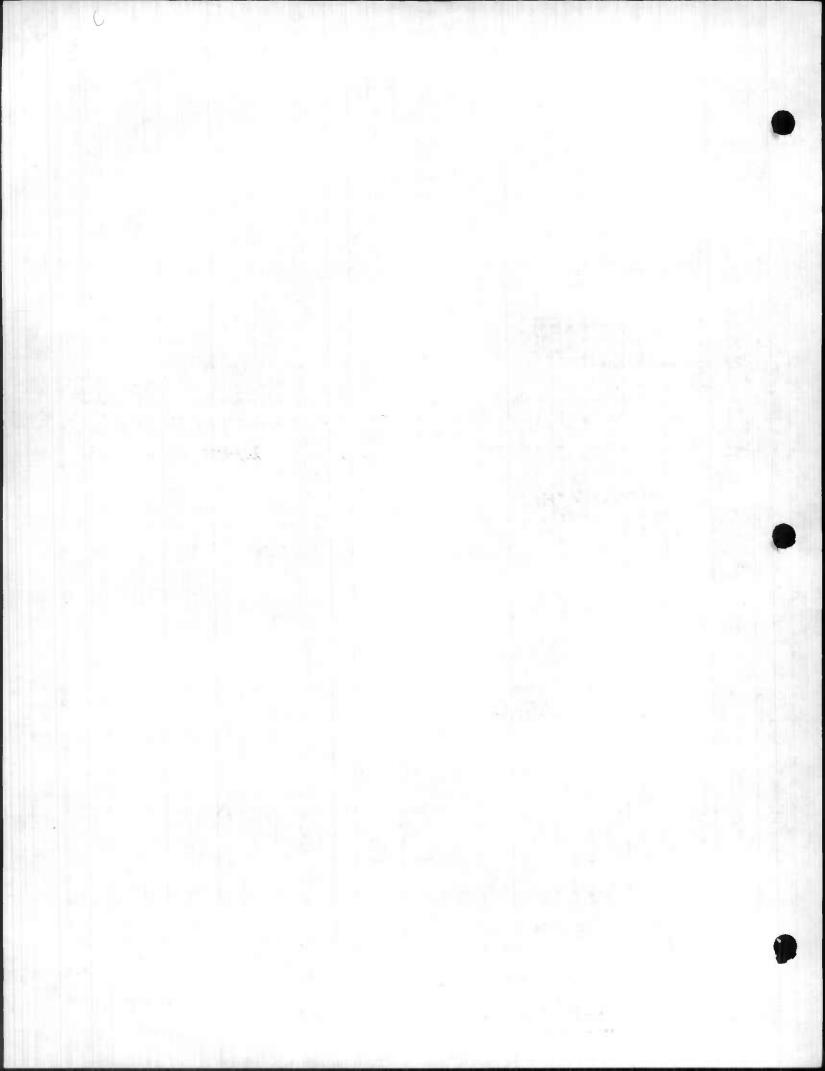


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 051.20

| an al | | 1. Decedent's Name (First, Middle, Last) | | | | | | | Reg. No. Date of Death | | 3. Time of Death | |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------|-------------------------------------------------------------------------|------------------------------------------|----------------------------------|---------------------------------|------------------------------------------------------------------|--|
| al | Faith N. Jon | | | | Month Druary | Day 200 | Year | 2:12am | | | | |
| er | 4a Facility Name (If not institution, gi | ve street and number |) | | | 4b. City, Town | | | 4c. County | | 2.12011 | |
| | 911 Weatherb | ee Road | | | J1 | Tows | on | | Ва | ltimo | ore | |
| | | Sex 7. A 1 □ M 2 🛱 F | ge (In yrs. la: | st birthday) Yrs. | If Under 1 Year Months Days | | Min. (| Date of Birth Month, Day, L - 24 - | | 9. Birthplac Country Balt | imore, MD | |
| | Usual Residence of Decedent | | 1 | | | | | | | | | |
| tor | MD Baltim | cation Tows | on | | | | 100 | I. Inside City Limits 1 Yes 2 No | | | | |
| Funeral Director | 10e. Street and Number 10f. Zip Code 10g. Citize 911 Weatherbee Road 21286 USA | | | | | | | | | What Country | 17 | |
| era | 11. Merital Stetus | 12. Was Deceden | t Ever in U.S. | 13. V | 1 | | ? (Specify | Yas or No- | | e - Americer | Indian. | |
| 5 | 1 Never Merried 2 Married 3 Widowed 4 ☑ Divorced | Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes: | ? | 13. Was Decedent of Hispenic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rice 1 ☐ Yes 2 ☑ No Specify: | | | | Specify: White | | | | |
| bet | 15. Decedent's E (Specify only highest gi | ducation | | 16a. Deced | lent's Usual Occu | pation | f working | | 16b. Kind of Ba | stry | | |
| Completed | Elementary/Secondery (0-12) 12th | 5+) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Secretary | | | | | Mercy | tal | | | |
| Be | 17. Father's Name (First, Middle, Las | n | | | | | | | Maiden Sumam | | | |
| 2 | John F. Pickel | Con Dring | | 405 14-11 | - A 44 (O | | | | rtholom | | la da t | |
| | 19e. Informant's Name/Relationship | (Type, Print) | | | I Address (Stree | | | | | | | |
| - | Barbara Johnson 20a. Method of Disposition | | 20h Ple | | Weatherh | рее коа | T - | | | | L286 | |
| | 1 ⊠ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci | | cen | netery, crem | vangelical | | Dete 20c. Location - City or Town, Stete 2-23-2000 Baltimore, Maryland | | | | | |
| | 21. Signature of Funeral Service Lice | nsee | | 22 | . Name and Addr | ess of Fecility | Josep | h N. | Zannino | Jr. | Funeral H | |
| | Marien 9 | annen | | | | | | | | | and 21224 | |
| edicai Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a. <u>Myc</u> | Due to (or a | as a conseq | uence of): | NFA | RC | TION | V | J | Days. | |
| | Part If. Other eigniffcant conditions Recent | | | | | iven In Part I. | | | obacco use co | | he cause of death? bly 45/Unknown | |
| | | | | | | | _ | 24a. Was a perform | med? | evail | e autopsy findinge able prior to pletion of cause eath? | |
| | | , | _ | | | | | 1 🗆 Ya | as 2 No | 10 | Yes 2 No | |
| | 25. Was case referred to medicel examiner? | Hospitel: | | | _ 0 | hor | | neck only on | | | | |
| - | 1 Yes 2 No 27. Manner of Death | 1 L Inpati | | VOutpation 8b. Time of | I SU DON | 4 LI NUIS | - | / | ence 6 Oth | | | |
| Certification: | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not l | | ay Year) | Injury | M 1 | Yes 2 No | | | | | | |
| | 4 Homicide determined | eet, factory, office | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | Houte Number, | | | | |
| edical | 29e. Certifier (Check only one) 10 Certifying Pl | nyelcian: To the best miner: On the basis of and manner s | of examinetio | edge, death n and/or inv | occurred at the ti restigation, in my | ime, date end p opinion, death | occurred a | due to the ca t the time, de | ause(s) and ma ete end place, | nnar as stat and due to ti | ted. he ceuse(s) | |
| | 29c. License number 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Month, Dey, Ye. 29d. Date signed (Mo | | | | | | | | | 0 | | |
| 1 | | | | | | | | | | | | |

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3a.m Barbara 19, 2000 February /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Joseph Richie Hospice Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Months Dsys Hours 219-28-1279 67 Yrs. Director Nov. 24, 1932 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show treumatic event, the Medical Examinat mast be notified at n/a Baltimore 1XX es 2 □ No Md. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 309 N. Carey Street Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritei Status 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 2 3 ☐ Widowed 4 ☑ Divorced n and Mental Hygiene. Ie marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Nursing 12th Grade Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Armeta Neal Edward Walker 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 7825 AylesFord Lane Laurel Md. 20757 nt of Health : Earl L. Spain son other 1 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Scemetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 Feb. 21 Baltimore, Md. Metro Crematory 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltir

23a. Part 1. Enter the disease, or complication that diused the death. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one cau 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Approximste Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final 1 west disease or condition resulting in death) Examiner Examiner 3 mouths Medastages Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 6 worths Carcinoma (L) Physician/Medicai Due to (or es e consequença of): the ed by the a 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by i 1 Yes 2 No 3 Probably 4 d'Unknown þ 24b. Were autopsy findings available prior to completion of cause of desth? 24a. Wes an autopsy Completed performed? 1 Ves 2 No 1 □ Yes 2 □ No director, 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6. Other (Specify) H639727 2 1 ☐ Yes 2 Ø No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: After Injury 1 Neturel 5 Pending i or Attending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 8 24 hours a 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and place, snd due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and dus to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medicai (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date sloned (Month, Day, Year)

Division of Vital

2/19/00

State Registrar 31. Date filed (Month, Day, Year)

2000

13. June 1 1. 12

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) R 27 fe

32. Registrar's Signature

8824 Winands Road.

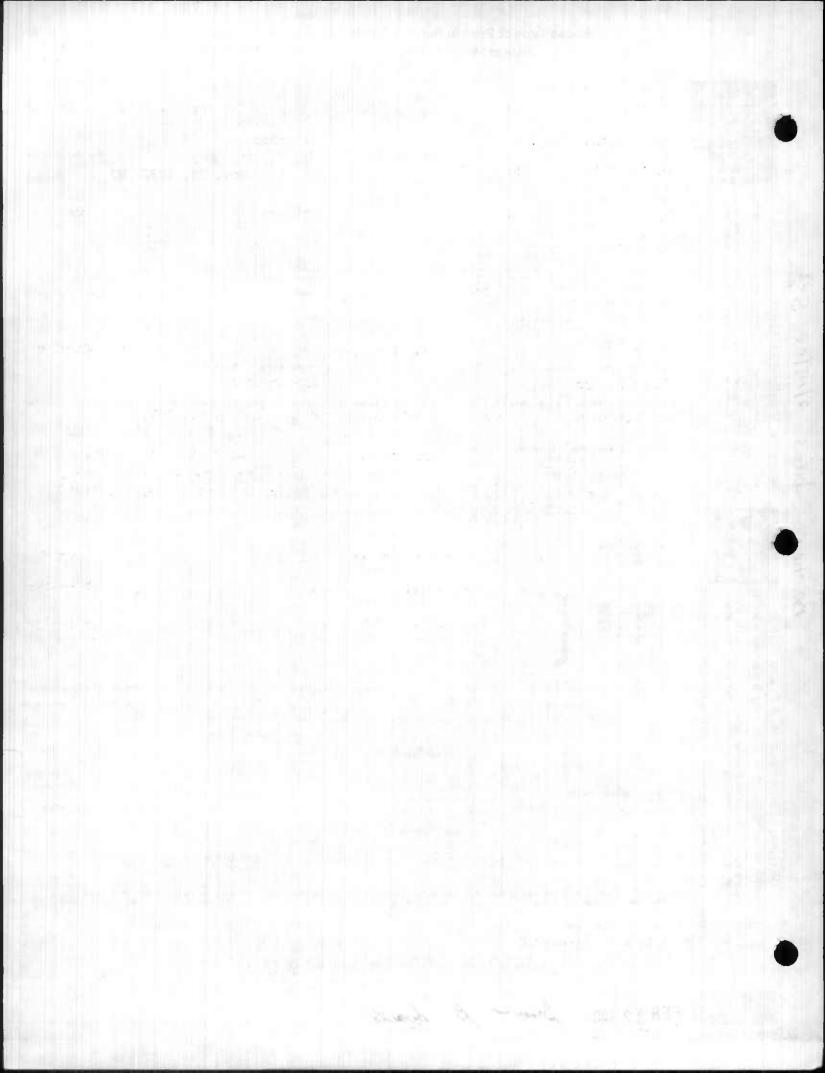
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B. Finn, M.D.

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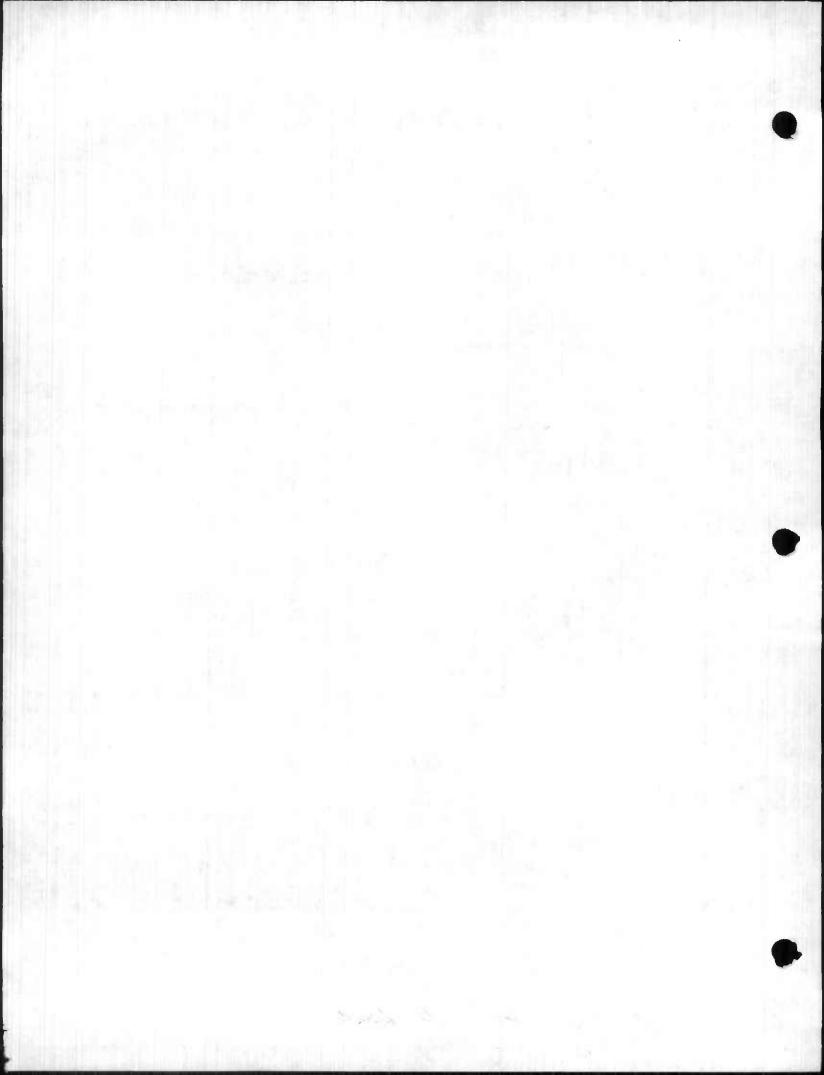
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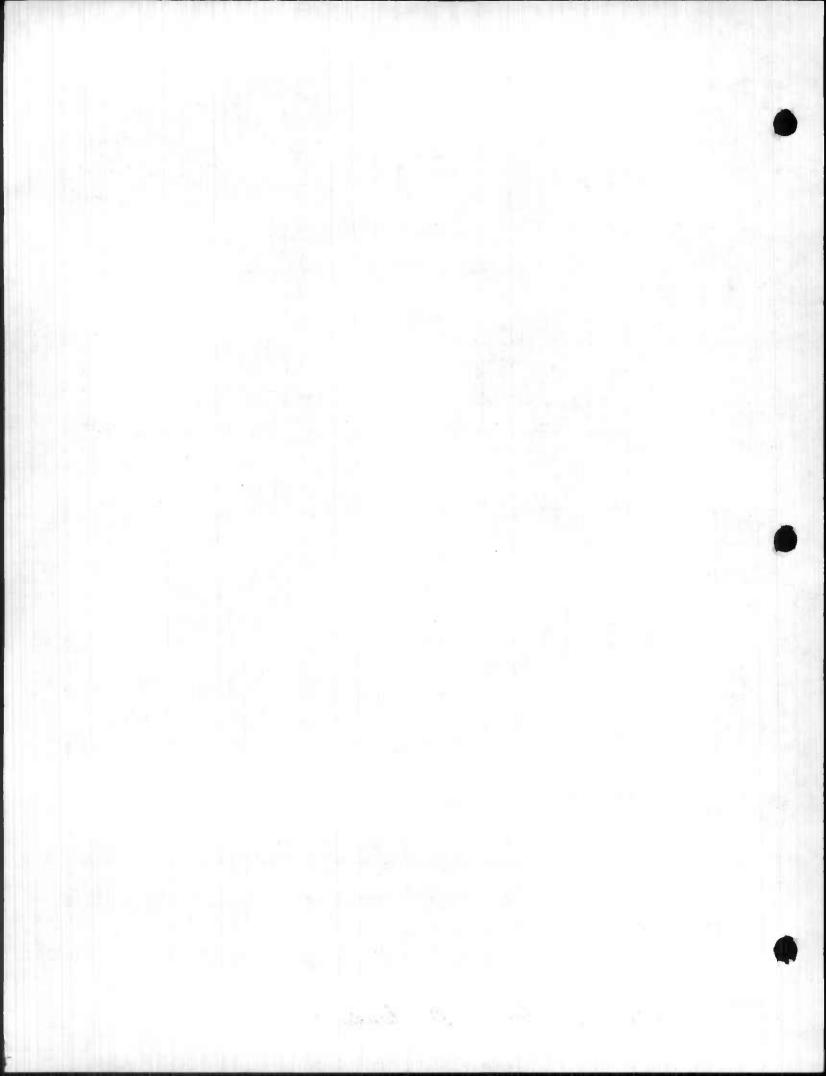
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 051.22

| | | Ce | rtificate of | Death | F | Reg. No. | 0 00456 | | | |
|-----------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------|------------------------------------------|---------------------------------|-------------------------------|------------------------------------------------------|--|--|--|
| | Decedent'a Name (First, Middle, Last) | | | | 2. Date of Dea | | 3. Time of Deat | | | |
| Physician /Medical | HATTIE JOHN | SON | | - | Je Month | Day 16 0 | 2000) 3:37 F | | | |
| | ta Facility Name (If not institution, give street and number | | | 4b. City, Town, or L | ocation of Death | | | | | |
| | North Arundel Hospital | | | Glen Bur | nie | Anne | Arundel | | | |
| uneral | | Age (In yrs. last birthday) | Months Days | | 8. Date of Birth (Month, Day | h Vearl | Birthplace (State or Fore Country) | | | |
| rector | 244-20-2443 1□M 2¬F | 82 Yrs. | Months Days | Hours Mill. | Sept. | 27,1917 | North Caroli | | | |
| - | Usual Residence of Decedent | | | | | | | | | |
| 3 | 10a. State 10b. County | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Lin | | | |
| Director | MD Anne Arundel | Severn | | | | - 1 | 1 ☐ Yes 20X | | | |
| e le | 10e. Street and Number | | 10f. Zip Code | | | 10g. Citizen of What Country? | | | | |
| a le | 1802 Long Leaf Way | | 21 | 144 | | USA | | | | |
| Funeral | 11. Marital Status 12. Was Deceder | nt Ever in U,S. 13. | Was Decedent of | Hispanic Origin? (Spoan, Mexican, Puerto | ecify Yes or No- | 14. Race | - American Indian, k, White, etc. | | | |
| 3 | 1 Never Married 2 Married 1 Yes 25 | No | 1 ☐ Yes 2 ☒ No | | riiouri, oto.j | | 21 1 | | | |
| by | 3 ☑ Widowed 4 ☐ Divorced Year or Date: | | 10 163 230 110 | opecity. | | Specify: | DIACK | | | |
| Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Dece | ident's Usual Occu | pation | ina | 16b. Kind of Bu | siness/Industry | | | |
| d | Elementary/Secondary (0-12) College (1-4c | r 5+) | (Give kind of work done during most of w life. DO NOT use retired) | | | | | | | |
| Ö | 5 | Home | emaker | | | Own Ho | | | | |
| Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | e (First, Middle, | Maiden Sumami | 9) | | | |
| 0 | William Jenkins | | Territoria | Martha | Ann Un | known | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) | 19b. Maili | ing Address (Stree | et and Number or Rui | ai Route Numbe | or, City or Town, | State, Zip Code) | | | |
| 77 | Uvell E. Reaves (Son) | 7834 | 4 Statesm | nan Street | , Sever | n, MD 21 | .144 | | | |
| | 20a. Method of Disposition | 20b. Place of Disponentery, cre | osition (Name of matory or other pla | ace) | Date | 20c. Location - | City or Town, Slate | | | |
| | **Burlat 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify) | A | | rial Park | 02/23/ | Elkridg | e, Maryland | | | |
| * | 21. Signature of Funeral Service Licensee | 2 | 2. Name and Addr | ess of Facility | | _ | | | | |
| Bouce | Hardesty Funeral Home, P.A. | | | | | | | | | |
| | 23a Part 1 Enter the disease or complications that cause | ed the death. Do not en | | ely Avenue | | | Approximate | | | |
| | 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each | line. | , | | | | Interval Between Onset and Death | | | |
| an al | Immediate Cause (Final | A | 0 | 1 | | | 0 / | | | |
| er | Immediate Cause (Final disease or condition resulting in death) a. All All All All All All All All All Al | | | | | | | | | |
| 5 | 210 | Due to (or as a conse | equence of): | | 1 | | | | | |
| 튵 | b. Chlo | ne ou | Murch | or au | men | eseas | 1 year | | | |
| Examine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a conse | quence of): | , | / | | | | | |
| 100000 | Cause. Enter Orioentying | | | | | | | | | |
| edical | resulting in death) Last | Due to (or as a consec | quence of): | | | | | | | |
| 8 | d | | | | | | | | | |
| ole - | | | | | | | | | | |
| Physician | Part II. Other eignificant conditions contributing to death | but not resulting in the | underlying cause g | iven in Part I. | | Yea 2 No | stribute to the cause of deal | | | |
| | Dialogles. | Dialello. | | | | | | | | |
| 1 by | | | | | 044 18444 | | 24b. Were autopsy findin | | | |
| ete | | | | | perlo | an autopsy rmed? | available prior to completion of cause | | | |
| Completed | | | | | | | of death? | | | |
| 000 | | | | | 101 | res 2 No | 1 ☐ Yes 2 ☐ No | | | |
| | 25. Was case referred to medical examiner? | | | 26. Place of Dea | th (Check only o | ne) | | | | |
| 2 | 1 Yes Hospital: 1 Inpe | itient 2 ER/Outpatie | nt 3 DOA O | ther: 4 Nursing H | ome 5 Resid | dence 6 Othe | or (Specify) | | | |
| | 27. Manner of Death 28a. Date of Ir | jury 28b. Time o | of 28c. Inju | ury at | 28d. Describe t | now injury occurr | ed | | | |
| atio | 1 ☑Natural 5 ☐ Pending (Month, I | 11,017 | M 1 Yes 2 No | | | | | | | |
| 9 | 3 Suicide 6 Could not be determined 28e. Place of building. | njury - At home, farm, st | ne, farm, street, factory, offica 28f. Location (| | | | (Street and Number or Rural Route Number, wm, State) | | | |
| Certification: | 4 nomicide building, | etc. (Specify) | | | City of Tov | mi, State/ | | | | |
| | 29a. Certifier 1 Certifying Physician: To the bea | st of my knowledge, deat | th occurred at the t | time, date and placa. | and due to the | cause(s) and ma | nner as stated. | | | |
| edical | (Check only 2 Medical Examiner: On the basis and manner | of examination and/or in | nvestigation, in my | opinion, death occur | red at the time, | date and place, a | and due to the cause(s) | | | |
| 100 | 29b. Signature and title of certifier | | 29c. Licer | nse number | | 29d. Date signed | (Month, Day, Year) | | | |
| , | Paul Clait | A | | 0 / 0 = = | 2 | 9/11 | 10 | | | |
| | rum o- Kanjom | em Mil |) 1)0 | 26307 | | 0/16 | 100 | | | |
|) | 30. Name and address of person who completed cause o | | Print) | | 200 | | | | | |
| | KANI S. KARIPINENI | 4000 A | MNAPO | LIJ KI | 1, 6A | LTIMO | RE MO26 | | | |
| State | 31. Date filed (Month, Day, Year) FFB 2 2 2000 | strar's Signature | 1 | | / | | / | | | |
| istrar | FFD 7 7 7000 /244 | - LJ. | MAN Way | | | | | | | |



| | Decedent's Name /Firet | Michilla I a | 1. Decedent's Name (First, Middle, Last) | | | | | | | | | 3. Time of Death | |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------|-------------------------|--------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------|--------------------------------------|--|
| Physician | Grace Miller Johnson | | | | | | | | 2. Dala of De Month Februa: | Dey | Year 2000 | 0004 | |
| /Medical | 4a Facility Nama (If not in | | | | | | | 4b. City, Town, or I | | 4 | | 0004 | |
| Examiner | Anne Aru | | | | er | | | Annapoli | | | Arund | le1 | |
| Colonial I | 5. Social Security Number | 6. S | | | Age (In yrs. last birthday) If Under 1 You | | | If Under 24 Hrs. | 8. Dete of Bir (Month, Da | | | ace (State or Foreigry) | |
| Funeral Director | 176-10-1235 Usual Residence of Deced | | □M 2KTXF | | | rs. Month | s Days | Hours Min. | April : | 3, 1915 | | nsylvania | |
| notified at inector | 10a. Stete 10b. 0 | | | | | | | | | | 10 | od. Inside City Limit | |
| or 28s-f s be notified Director | | Anne A | rundel | | Dav | idsonv | | | | | | | |
| 0 % 0 | 10e. Street and Number | | | | | 101. 4 | Zip Code | | | 10g. Citizen of | What Count | ry? | |
| nunt. | 3475 Olympi | a Road | | and and Free | | 42 Was Day | | .035 | naitu Van au Na | US | A e - America | n Indian | |
| at, or hams 23 Examiner must by Funeral | 11. Marital Status 1 Never Merried 2[342Widowed 4 Di | | 12. Wes Dec Armed F 1 Tes If Yes, G Year or I | orces? 2/XNo live | rin U,S. | If Yes, sp | pecify Cub | dispanic Origin? (Sp an, Mexican, Puart Specify: | o Rican, etc.) | | ck, White, e | otc. | |
| ygiene ver than 'natural', or the c, the Medical Examina Completed by Fu | 15. Decedent's Education (Specify only highest grade completed) Elementary/Şeçondary (0-12) College (1-4or 5+) | | | | 16a. | Decedent's Us (Give kind of v life. DO NOT | Usuel Occupation of work done during most of working Of use retired) 1 6b. Kind of Business/Industry | | | | | | |
| Co the | UNK | | | | Но | memake | r | | | Own F | | | |
| B even | 17. Father'a Name (First, A | | | | | | | 18. Mother's Nan | | | ne) | | |
| To To | Frank T. Mi | | | | 1 | | | | Daniel | | | | |
| le m | 19e. Informant's Name/Re | | | | | | | and Number or Ru | | | | | |
| m 27 her tr | Nancy A. Ro | | ughter | | | | | Road, D | | | | | |
| rtment of H rtant: If lise njury or oth | 20a. Method of Disposition 1 Burial 2 CCrem 4 Donetion 5 Do | ation 3 🗆 | | 1 | cemetery | Disposition (A crematory of Crema | r other pla | ce) | Date 02/22/ 2000 | 20c. Location Baltin | | | |
| Depart Import any in page | 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | | | | | | 01 | | |
| Medical caminer Examiner | Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Condisc or hy thunned Due to (or as a consequence of): Or disc or hy thunned Due to (or as a consequence of): Myo conical or faction Myo conical or faction | | | | | | | | | | | | |
| g physicia as the bur Tedical | Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | • { | d | // Due | no g h | onsequence o | (): | taclia | | | | | |
| ed fo | Part II. Other significant o | onditions co | ns contributing to death but not resulting in the underlying ceuse given in Pert I. | | | | | | 23b. Dld | tobacco usa co | ntribute to | the cause of deat | |
| igned by the be detach by Phy. | Hyn | rber | yw | | | | | | 10 | Yaa 2⊠No | 3 Prob | ebly 4 Unknow | |
| s been s 2 should pleted | Diabets mellets tow I | | | | | | <u>II</u> | | 24e. Wes an autopsy performed? 24b. Were autopsy available prior complation of of death? | | | ilable prior to nplation of cause | |
| page Com | | | | | | | | | 10 | Yes 2 No | 1□ | Yas 2□ No | |
| certificate rector, pag | 25. Waa case referred to n examiner? | nedical | | | | | | 26. Place of Dea | th (Check only | one) | | | |
| To F | 1 Yes 2 No | | | 7 | 2 ER/Out | patient 3 | DOA Ot | her: 4 Nursing H | ome 5 Res | idence 8 □Otl | ner (Specify |) | |
| or death. ector: After th by the funeral ification: | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 2 No Time of Injury Work? 3 Suicide 6 Coule determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Log | | | | | | | | | Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| of Direct Bd in by | | | | | | | | | | | | | |
| Je Je | | | niner: On the b | | amination and | | | | | and due to the cause(s) and manner as stated. red et the time, date and place, and due to the cause(s) | | | |
| Peter Port | 29b. Signature and little of certifier 29c. License number | | | | | | | | | 29d. Dete signe | ed (Month, I | Day, Year) | |
| within 24 hou To the Funer completely fil Medical | | | | | | | 7. | 2001110 | | 110/0 | 1201 | . 77 | |
| | · \ | h | MA | 1) | | | () (| 103143 | | 02/21 | 1200 | | |
| within 24 h To the Fur completely Medic | 30. Name and address of p | | | se of deat | | | | 1N ST 1 | | / - (| 120 | | |



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State of Maryland / Department of Health and Mental Hygiene 05424 Certificate of Death Reg. No 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** ones 4:30 A.H 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Monroe Ba Himore If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months 220-24-9124 12M 2DF Deys Hours Min 5.0 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Ves 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code me 23a or 2 21 onrue Completed by Funeral death 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter of nent of Health and Mentel Hygiene.
snt: If Hem 27 is marked other than "natural", or han ury or other treumatic event, the Medical Estantion. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 Black 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education onstruction Company Elementary/Segondary (0-12) College (1-4or 5+) Worker grade postru etron 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) 0 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Retetionship (Type, Print) reportant: If New 27 is re y injury or oth-Ba Ho, Md 21217 Sarah Wite 707 N Monroe 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, cremetory or other ple 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Department Important; h eny injury o Cemetery 2-22-00 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funegal Service Licensee azzh Balto, Wabash nd 21215 Avenue 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear reliure. List only one cause on each time. Approximate Interval Between Onset and Deeth **Physician** /Medical tmmediete Cause (Finat Cell man the s Carcinoma disease or condition resulting in death) Examiner Due to (or es a consequence of) Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, physician Due to (or as a consequence of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findinga available prior to completion of cause of death? 24e. Was an autopsy performed? al No certificate 1 Yes 21400 funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 BNaturai 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours efter death. To the Funerel Director: A 2 Accident 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner station. 29e. Cartifier (Check only one) 29b. Signature and jitle of certifig 29c. License number 29d. Dete signed (Month, Day, Year) 21, 051426 fe brunny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Elliot

31 Date filed (Month, Day, Year) FEB 2 2 2000

Rothschild

DHMH 16 Ray 6/95

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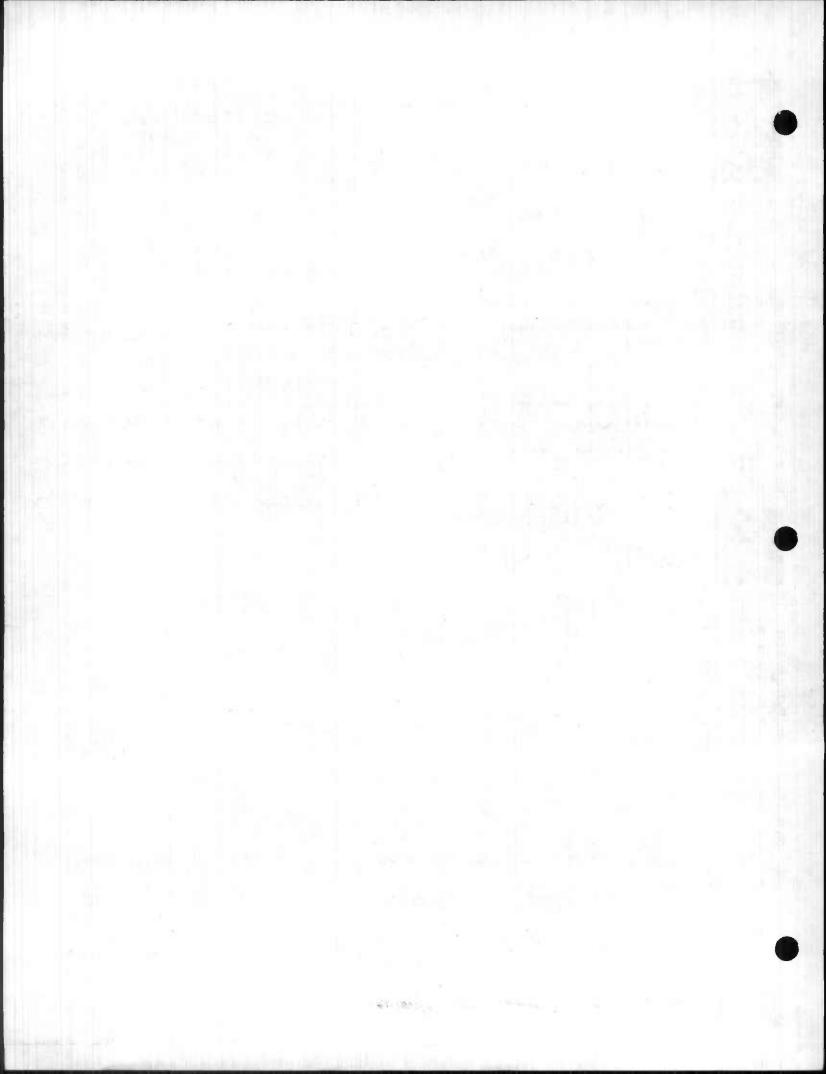
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05425 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death February 17, 2000 5:15am Sarah Jackson 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland # Under 1 Year 8. Date of Birth Month, Day, Year) March 26, 1920 7. Age (In yrs. last birthday) Days Months Hours 10 M 20 F 79 213-44-3534 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Washington, DC 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6703 20012 United States 2nd St. NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Black. Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5709 Cypress Creek Dr. Apt. 301 Hyattsville MD 20782 Earl Jackson, Jr. 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Fe Pate 24 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Harmony Memorial Park 4 Donetlon 5 Other (Specify, Takoma Funeral Home 21. Signeture of Furieral Service Licensee 22. Name end Address of Facility 254 Carroll St. NW Washington DC 20012 ded disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, fart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last OBSTRUCTIVE RONIC 4 RDIOMYO 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TACHYCARD 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitei: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work?

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. After this certificate or Attending Physician: funeral To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af filled in by the

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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23a or

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Hygiene.

or thought of Health and Mental Hy this if them 27 is mention

Physician

/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. VENTRICULAR 25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Beath Netural 2 Accident 5 Pending investigation 1 | Yes 2 | No 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

mar M.D.

completely

State Registrar

31. Date filed (Month, Dey, Year) FEB 2 2 2000

29e. Certifier

(Check only one) 29b. Signeture and title of

> SUITE 380 32. Registrer's Signeture Beneva

Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

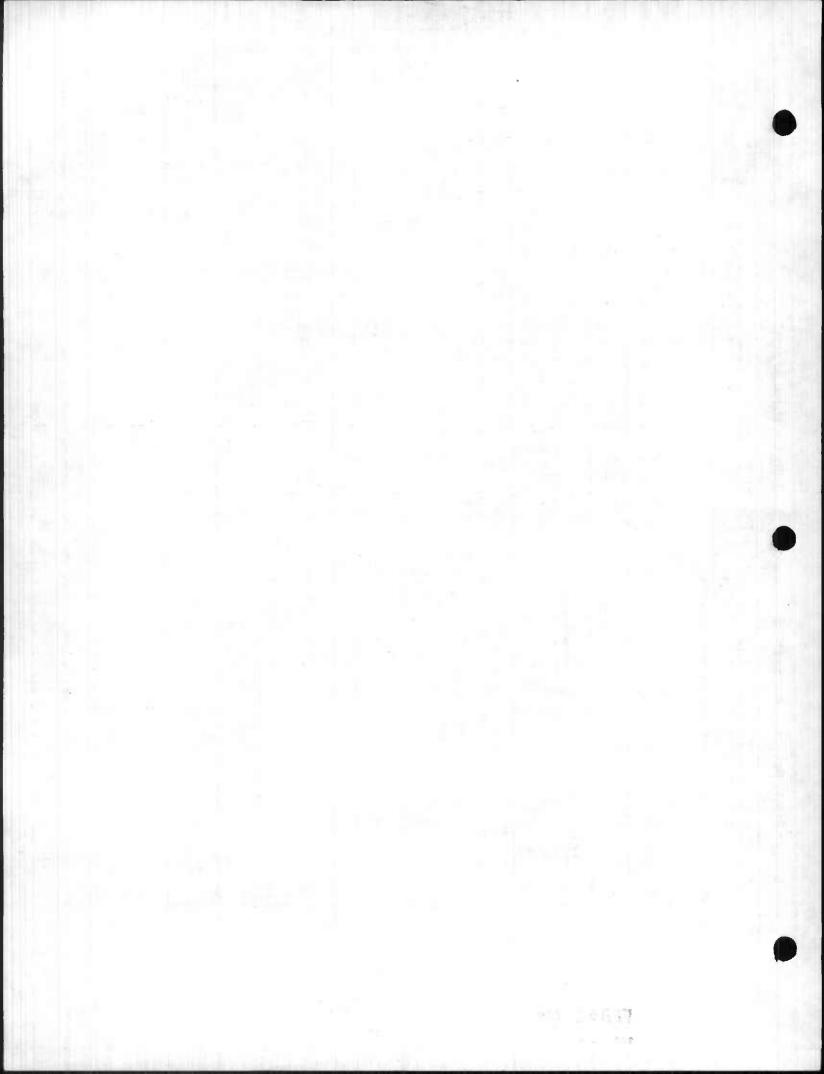
29c. License number

29d. Dete signed (Month, Day, Year)

7610 CARROLLAVE. TAKOMAPARK, MD

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** James King FEBRUARY 8:50am /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Fort Howard Hospital Baltimore If Under 1 Year If Linder 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 15 M 2□ F 251-14-0557 85 Director 1915 SC Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Baltimore Director Md. n/a No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural, or items 23s or 2909 Violet Avenue 21215 USA Funeral death 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forcas? 14. Raca - American Indian, Black White etc. filed within 72 hours after ☐ Yes 2 ☐ No Yes Give 1 Never Married 2 Married 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: Black by 3 ☐ Widowed 4 ₩ Pivorced Year or Dales: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Important: If item 27 is marked other than 's any injury or other traumatic avant, the Man once. Elementary/Secondary (0-12) College (1-4or 5+) Gardener Private Families 5th Grade altimore, Maryland 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Mattie Robinson Flock King 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3836 Dolfield Avenue Baltimore, Md. 21215 Shirley Brown niece 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Deurial 2 Cramation 3 Removal from State 4 ☐ Donelion 5 ☐ Other (Specify) Garrison Forrest VeteransFeb. 23 Owings Mills, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Sarvice Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Dutter 23a. Pert1. Enter the disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical 13 MONTHS Immediate Cause (Final CANCER RIGHT MAXILLARY SINUS disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sician and burial-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of) 100 attending p P.O. \$ P Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yea 2 No 3 Probably 4 ☑ Unknown EXTENSION OF CANCER TO THE RIGHT ORBIT Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parformed? SEIZURE DISORDER, HYPERTENSION 1 Yes 2 No 1 ☐ Yes 2 X No certificate Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical axaminar? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 TYes 2 No 1 🔯 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28h Time of 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Nelurel 5 Pending death. 1 Tes 2 No Investigation 2 Accident hours after deat neral Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and mannar as stated.

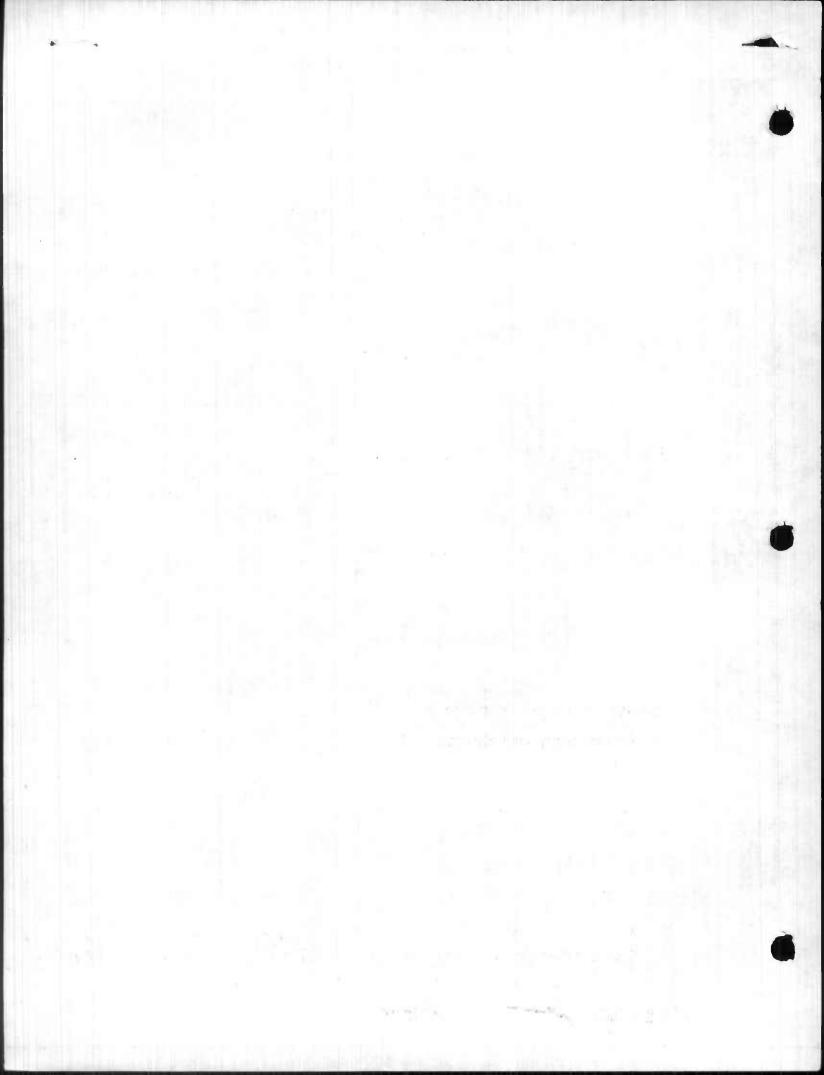
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of parson who completed cause of death (Item 23a) (Type, Print) AURORA TAN, MD. 9600 NORTH POINT ROAD, FORT HOWARD, MD. 21052 31. Date filed (Month, Day, Year) 32. Registrary Signature

DHMH 16 Rev 6/95

Registrar

FEB

2 2 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** YNOR2 MARGARET 6:11AM FEBRURY 20 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSDITAL CENTER If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F 577-58-4954A 90 Director March 6,1909 Germany Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits MD 1 Yes 200 No Director Anne Arundel Odenton 26a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 238 478 Rita Drive 21113 USA Funeral Herra 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. Med within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clothing 12 Seamstress 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Ments! H antt. If them 27 is marked oth lary or other traumatic sysen Be Barbara Schreiber Michael Mathes 19a. Informant's Name/Reletionship (Type, Print) (Grand-19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter) 480 Rita Drive, Odenton, MD 21113 Hannelore Miliotis 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 02/23/ 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removal from State Department of Important: If any injury or Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Annapolis, MD 21. Signature of Funeral Service License 22. Neme and Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final CONGESTIVE HEART FAILURE disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CORONARY HEART DISEASE

Due to (or as a consequence of): The law requires that the death certificate be executed the buriel-transit and Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disaase or Injury that initiated events resulting in death) Last ATRIAL FIBRILLATION

Due to (or as a consequence of): Physician/Medicai CHRONIC OBSTRUCTIVE PULMONARY DISCASE Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed page 2 should be de þ 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 2 No certificate 1 Tyes 1 □ Yes 2 □ No director. 25. Was case raferred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA shis funeral 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident

Box 68760. P.O. Records, Division of Vital or Attending Physician: ne Hospital or Attending n 24 hours after death.

Medical completely To the To the To the

filled in by

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

MEDICAL REIDENT, HOUSE STAFF

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

29c. License number AS2441614-A10

1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29d. Deta signed (Month, Day, Year) FEBRUARY 20, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

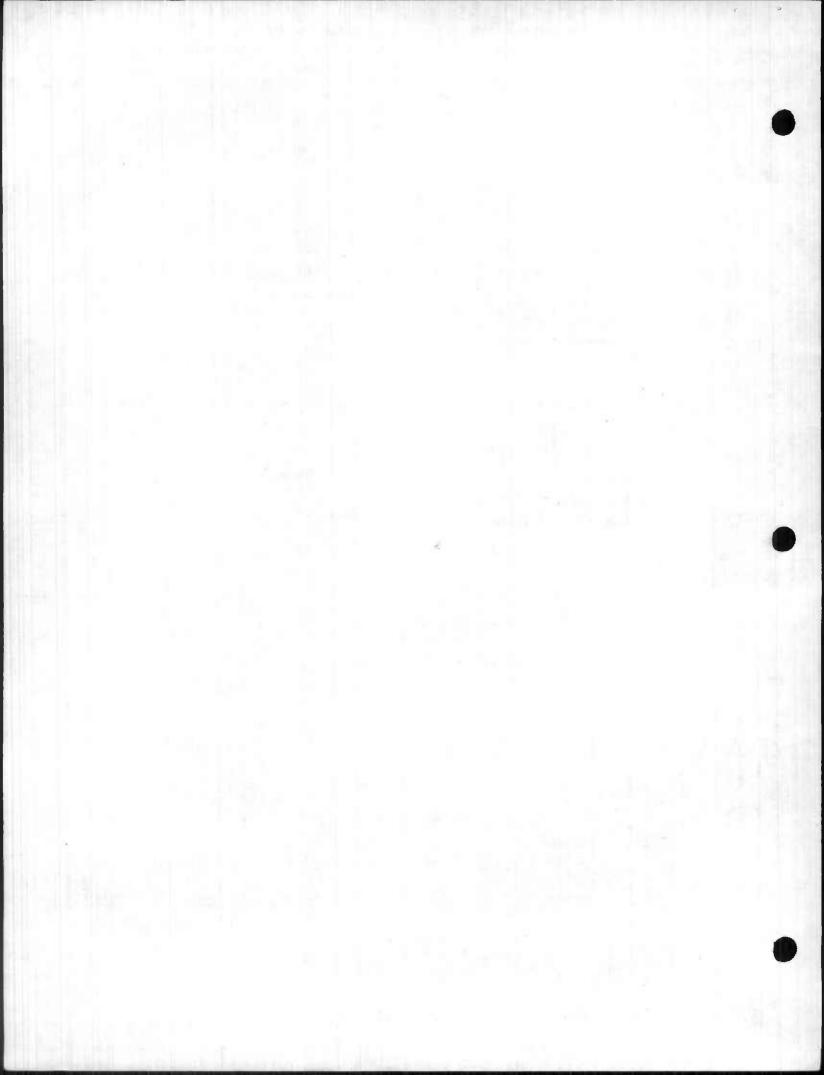
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

SHIV & PATIC 3001 SOUTH HATVUVER STREET BALTIMORE MD 21225 31. Date filed (Month, Pay Year) FEB 2 2 2000

State Registrar

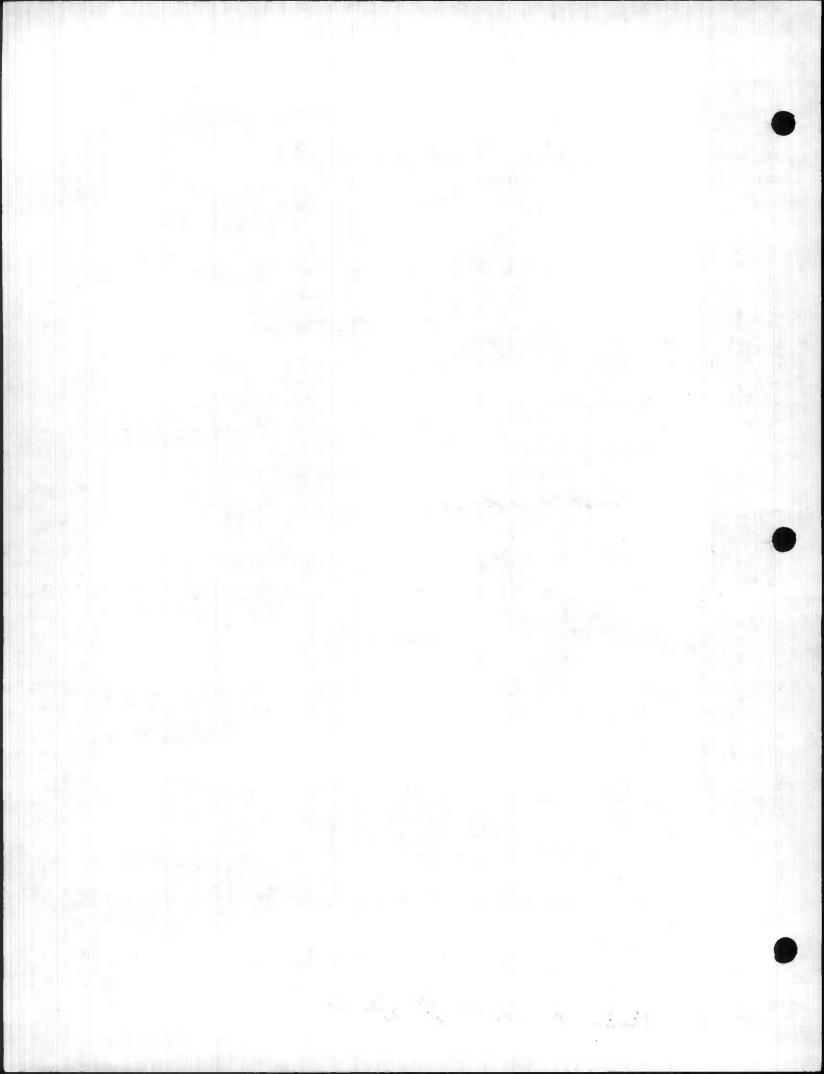
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 1:13 p.m. **Physician** FEBRUARY Pr 2000 365eph 4a Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL H Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) NOV. 1,1914 5. Social Security Number 9. Birthplaca (State or Foreign **Funeral** Months Days Hours MARY LAND Yrs. 213-03-7218 85 Director Usuet Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limita 1 Yes 2 No Directo BALTIMORE 23a or 28a-f N/A 10e. Street and Numbar 10f. Zin Code 10g. Citizen of What Country? U.S.A. Funeral 2203 DUKER COURT 21231 12. Was Decedent Ever in U,S. Armed Forces?

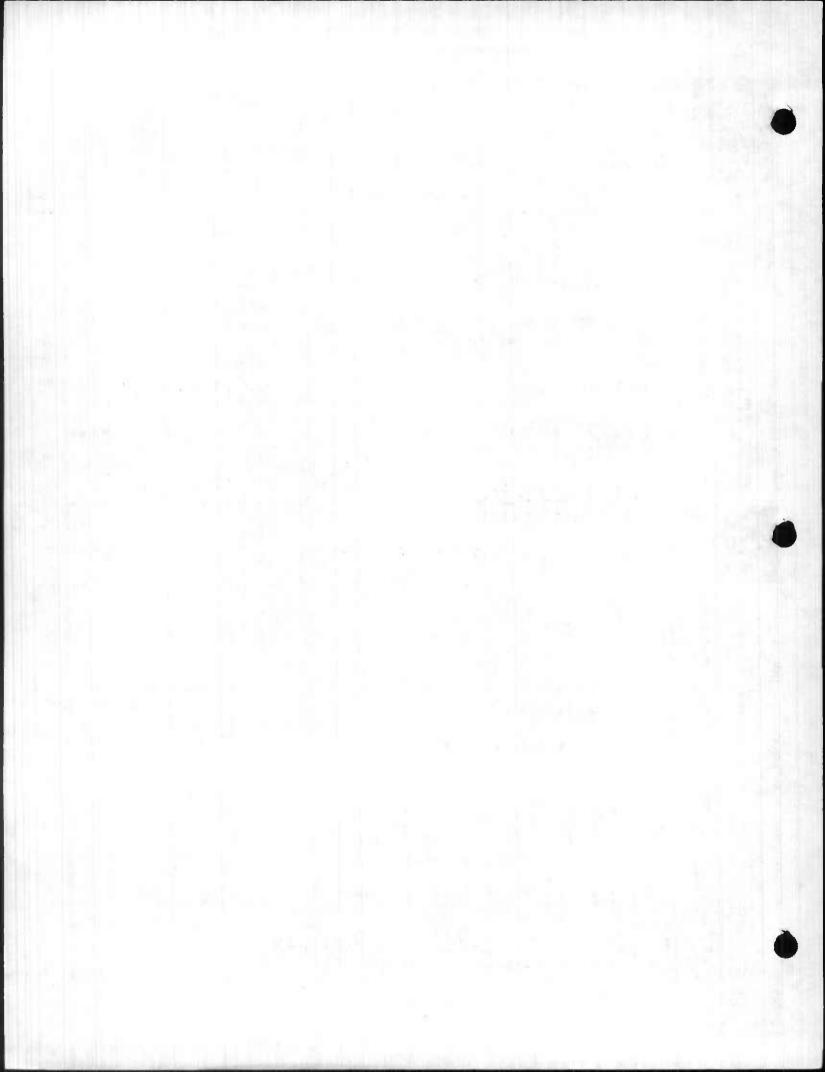
1 Yes 2 No If Yes, Give Yeer or Detes: 1943-46 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married b 21215-0020 1 Yes 2 No Specify: þ Specify: 3\O\Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiera. Elementary/Secondery (0-12) College (1-4or 5+) 8 TAILOR CLOTHING Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 8 is marked of STELLA NOWAKOWSKI WALTER KRATZ 19a. informant's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health. Important: if Item 27 I 202 N. BOLTON STREET, NEW OXFORD, PA. 17350 PATRICIA HEFFNER/ DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removat from State STANISLAUS CEMETERY 2/23/00 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD. 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finet disease or condition resulting in deeth) Examiner Atherosclerotic Cardiovasular Posease Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last and Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by to 1 Yea 2 No 3 Probably 4 Onknown Heart Failure ٥ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificata 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 DER/Outpatient 3□ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending Investigation 1 Netural death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 660 North Wolfe Street Hospital Nelson 106 Bathmore 5 31. Date filed (Month, Dey, Year) 33. Registrer's Signeture MO State 2128 FEB 2 2 2000 Registrar



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 54 29

| | | Certificate of Death | Reg. No. | 03463 | | | | | | | | |
|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|
| Physician | 1. Decedent's Nama (First, Middle, Last) FRANK CHARLES KALIVODA, SR. | | 2. Date of Death FEBRUARY 19, 2000 | 3. Time of Death 10:30 AM | | | | | | | | |
| /Medical Examiner | 4a Facility Nama (If not Institution, giva street and number) 1264 DELMONT ROAD | 4b. City, Town, or Loc SEVERN | | ith | | | | | | | | |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last bird 219-05-6385 172 M 2□ F 90 | YIS. | 8. Date of Birth (Month, Day, Year) 9. Bir Co | thplaca (State or Foreign ountry) | | | | | | | | |
| natural', or itema 23a or 28a-f ahow deal Examinet must be notified at sted by Funeral Director | Usual Residence of Decedent | | | | | | | | | | | |
| ahow at | 10a. State 10b. County 10c. City, Town or Location 10d. MARYLAND ANNE ARUNDEL SEVERN | | | | | | | | | | | |
| be nothed be nothed Director | 10e. Street and Number | SEVERN 10f, Zip Coda | 10g. Citizen of What Co | 1 ☐ Yes ANNO | | | | | | | | |
| 23a or | 1264 DELMONT ROAD | UNITED ST | | | | | | | | | | |
| rai', or items 23a or 28a-f ahov Examiner must be notified at I by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever In U.S. Armed Forcas? 1 Yas 2 No If Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (Spett Yes, specify Cuban, Mexican, Puerto F □ Yes 2 | erican Indian, te, etc. ITE | | | | | | | | | |
| 'natural', edical Exa | 15. Decedent's Education (Specify only highast grada completed) | Decedent's Usual Occupation (Giva kind of work dona during most of workin life. DO NOT use retired) | 16b. Kind of Business | /Industry | | | | | | | | |
| | Elementapy/Secondary (U-12) College (1-4or 5+) | 'life. DO NOT use retired) CLEANING & REPAIR | | | | | | | | | | |
| 7 is marked other than traumatic avent, the M To Be Comp | 1.00 | | | PACHOLIK y or Town, State, Zip Code) 144 Location - City or Town, State GLEN BURNIE, MARYLA P.A. | | | | | | | | |
| marked other imatic avent, I | 17. Father's Name (First, Middle, Last) | 18. Mothers Name | (First, Middle, Maiden Sumame) | | | | | | | | | |
| To affe | CHARLES KALIVODA | | SEPHINE PACHOLIK | | | | | | | | | |
| la marked o raumatic ave To Be | | . Mailing Address (Street and Number or Rural | | Zip Code) | | | | | | | | |
| | | 64 DELMONT ROAD SEVE | ERN, MD 21144 | Town Chate | | | | | | | | |
| Important: If item 2 any Injury or other DDCB. | r⊟tiwal 2 □ Cremation 3 □ Removal trom State cemeter | y, crematory or other place) FEB. 21 AVEN MEM. PK. 2000 | ., | | | | | | | | | |
| Importa any Inje ance. | 21. Signature of the disease of complications that caused the death. Do not shock, or heart tailure. List only one causa on each line. | 22. Name end Address of Facility KIRKLEY-RUDDICK FUNE 421 CRAIN HWY, S.E. | CRAL HOME P.A. | 21061 Approximate interval Between | | | | | | | | |
| edical miner | immediate Cause (Final disease or condition resulting in death) a. Caygative (H | Lear Soulue consequence oi): Lear Sociedans | | Onset and Death 29 less. Zrum | | | | | | | | |
| attending physician and for use as the burnel transfication of clan/Medical Examiner | 0. | consequence ot): | | Choste | | | | | | | | |
| od for | Part II. Other aignificant conditions contributing to death but not resulting in | the underlying cause given in Part I. | 23b. Did tobacco use contribute | a to the causa of death? | | | | | | | | |
| igned by the attendit be detached for use by Physician/ | Clemis buy Duesine | | 1 Yea 2 No 3 Probably 4 Monks 24a. Was an autopsy performed? 24b. Were autopsy tindi available prior to completion of caus of death? | | | | | | | | | |
| 2 should 2 should pleted | Climin buy Duceire | | | | | | | | | | | |
| page Com | | | 1 ☐ Yas 2 ☒No | 1 Yes 2 No | | | | | | | | |
| entific ector | 25. Was case reterred to medical examiner? | 26. Place of Death | (Check only one) | | | | | | | | | |
| T T | | | ne 5 Residenca 6 Other (Specify) 8d. Describe how injury occurred | | | | | | | | | |
| al Director: After t led in by the funer Certification: | 2 Accident investigation 3 Sulcide 6 Could not be | M 1 Yes 2 No | 295 Location / Otract and Number or Purel Pouts Number | | | | | | | | | |
| al Director: | 4 Homicide determined building, etc. (Specify) | City or Town, State) | tion (Street and Number or Rural Route Number, or Town, State) | | | | | | | | | |
| To the Funeral Directions of the Funeral Direction Completely filled in Medical Cert | 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and and manner stated. | , death occurred at the time, date and place, a d/or investigation, in my opinion, death occurre | nd due to the cause(s) and manner and at the time, date and place, and du | s stated. a to the cause(s) | | | | | | | | |
| Me | 29b. Signature and title of certifier. | 29c. License number | 29d. Data signad (Mon | th, Day, Year) | | | | | | | | |
| _ | · /weller /10 | NO 26664 | FEBRUARY 21 | 1, 2000 | | | | | | | | |
| 5 | 30. Name and address of person the completed cause of death (Item 23a) (| Type, Print) HCLOWO /US = 106 | Glas Surre Ils | 2106/ | | | | | | | | |
| State | 31. Date filed (Month Day, 2002 2000 32. Tegistrar's Signature | 9 Pravi | | | | | | | | | | |

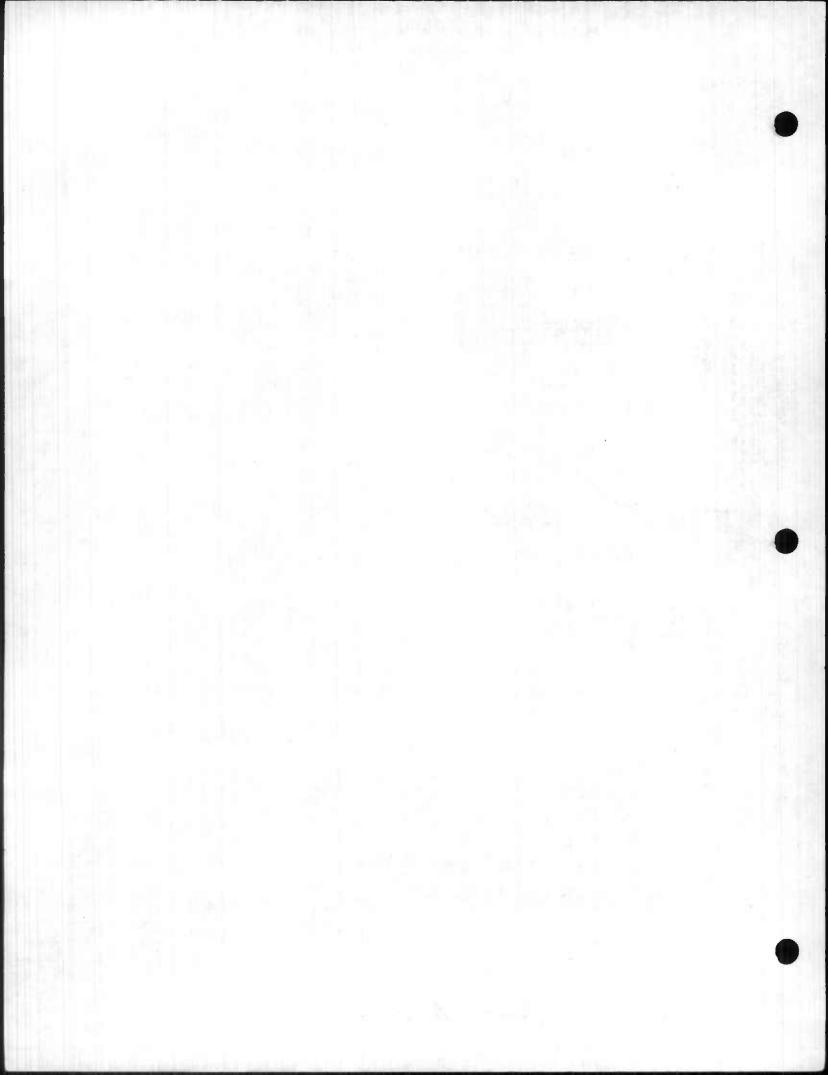


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

05430

1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** GERTRUDE KERMIISCH 3:50 PM FEBRUARY 18, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN, BALTIMORE 7. Age (In yrs. last birthday) | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | No 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2K)F Director 218-09-8699 MD. **Uauai Residence of Decedent** with the Manyland 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits ahow r 28a-f show BALTIMORE BALTIMORE 1 Tyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? h and Mental Hygiene. 7 is marked other than "natural", or hams 23s or traumatic event, to Medical Examinational 3 LEAFYDALE COURT 21208 USA Funeral 14. Race - American indian, Black, White, etc. 11 Marital Status Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hiapanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frem eny Injury or other traumatic event, it a Medial Exercise. 1 ☐ Yes 2 X No If Yes, Give Year or Dates; 1 Never Married 3 Married Baitimore, Maryland 21215-0020 1□Yes 2□No Specify: Specify WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working file. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **ABRAHAM** WELSH ELIZABETH 19a. Informant's Name/Relationship (Type, Print)
HOWARD KERMISCH/ HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 LEAFYDALE COURT BALTIMORE, MD. 21208 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 2/20/2000 WOODLAWN, MD. HEBREW YOUNG MEN 21. Signature of Phoral Segue License 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 23a. Part1. Enter the disease, or complications that redused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feiture. List only one cause or bach line. Approximeta Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) ACCIDENT · CEREBRO VASCULAR Examiner Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown DIABETES Records, þ 24e. Wes en autopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death? Completed DERTENSION page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s efter death. 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and piece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 2 29c. License number 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) 2000 15. S. RAO. M.D 8 043462 FEBRUAR CENTER, RANDALLSTOWN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL MORTHWEST 31. Date filed (Month, Day, Year) FEB 2 2 2000 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** February 3:50 pm Annie Ruth Kues 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner Baltimore Union Memorial Hospital 8. Date of Birth (Month, Day, Year) NOV. 9, 1933 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (Stata or Foraign **Funeral** Days Hours 1□M 2⊠F South Carolina Yrs. 66 Director 246-42-3144 with the Marylend 10a. Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-(show the Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? U.S.A. 21224 3700 Fait Avenue Funeral death 12. Was Decedani Evar in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem Z7 is marked other than "natural", or the any injury or other traumatic event, the Medical Examine Pages. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2CMarried altimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crafts Floral Designer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mandy Benton Raliegh Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 3700 Fait Avenue, Baltimore, Maryland 21224 William R. Kues (husband) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition ₩Burial 2 Cramation 3 Ramoval from State 2/22/2000 Baltimore, Maryland Sacred Heart of Jesus 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sentile Licensee 22. Nama and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pook, or heart failure. List only one cause on each line. Interval Batween Onset end Deeth Physician Immediata Cause (Finel disease or condition resulting In death) /Medical Coronary Disease 20 years **Examiner** Due to (or es a consequence of): Examiner physician and the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated avents resulting in death) Last Due to for es a consequença of): certificate be exec Physician/Medical Due to (or es a consequence of): 98 use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Division of Vital Records. by 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed page 2 s has 200 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 218 No Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 28e. Dete of Injury (Month, Day Year) luneral 27. Manner of Death 28b. Time of Injury 28d. Dascribe how injury occurred 28c. Injury et Work? Certification: After or Attanding Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at tha time, dele end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edical completely (Check only one) To the F within 2 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Dala signed (Month, Day, Year) AT 2438946 -N21 ebruary 20 2000 30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print) Baltimore, M.D. 21218 201 East University Parkway LAUZUN M.D.

DHMH 16 Rev 6/95

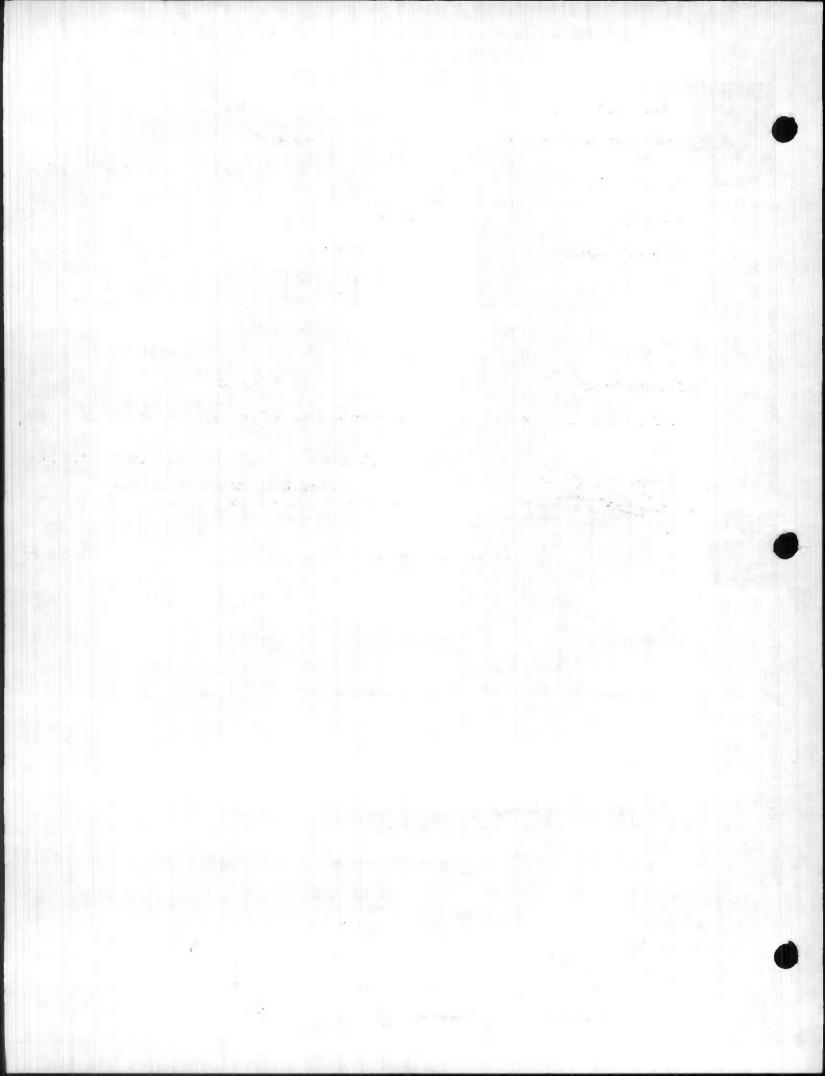
State

Registrar

31. Date filed (Month, Dey, Year)

FEB 2 2 2000

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 06, 2000 10:15 cation of Death SHARON LEWIS 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Loc STELLA MARIS HOSPICE (MERCY) BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Days Hours Months Country) 1□M 2□F 521-68-3193 53 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4008 DUVALL AVE. U.S.A. 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Merried 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DATA OPERATOR BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) AMOS LEWIS NADINE LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4546 MARBORHALL RD BALTIMORE MD 21239 REDDY MINNIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 X Burial 2 Cremetion 3 Removal from State KING'S MEM. PARK FEB. 71,2000 RANDALLSTOWN MD 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee ELIGENE N 22. Name and Address of Facility ESTEP BROS FUNERAL SERVICE PA WALKER 1300 EUTAW PL BALTO, MD 21217 er the mode of dying, such as cardiac or respiratory arrest, death. Do not enter Approximate Interval Between Onset and Death Immediate Cause (Final Curve Surun disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how infury occurred 28c. Injury at Work? 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed P.O. Box 68760, USB Records. certificate Division of Vital funeral

Examiner Physician/Medical ate has been signed page 2 should be de þ Completed Hospital or Attanding Physician:
 Hours after death.
 Huneral Director: After this certifica Be Certification: To filled in by

Physician

/Medical

Examiner

Director

Funeral

À

Completed

Be

2

Funeral

Director

nd Mental Hyglene. Imarked other than "natural", or flarma 23a or 28a-f ahow umatic avant, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: if Itam 27 Ia marked other than "natural", or ite my or other traumatic avant, ne Medical

permit. Page Department of Important: If any Injury or page.

Physician /Medical

Examiner

21215-0020

Baitimore, Maryland

Medical To the Hose within 2 To the Functional

4 Homicide

31. Date filed (Month, Day, Year)

FEB 2 2 2000

29a. Certifier

State Registrar 29b. Signature and title of cartifier

3

Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 040854

But

29d. Date signed (Month, Day, Year)

Bultzmar

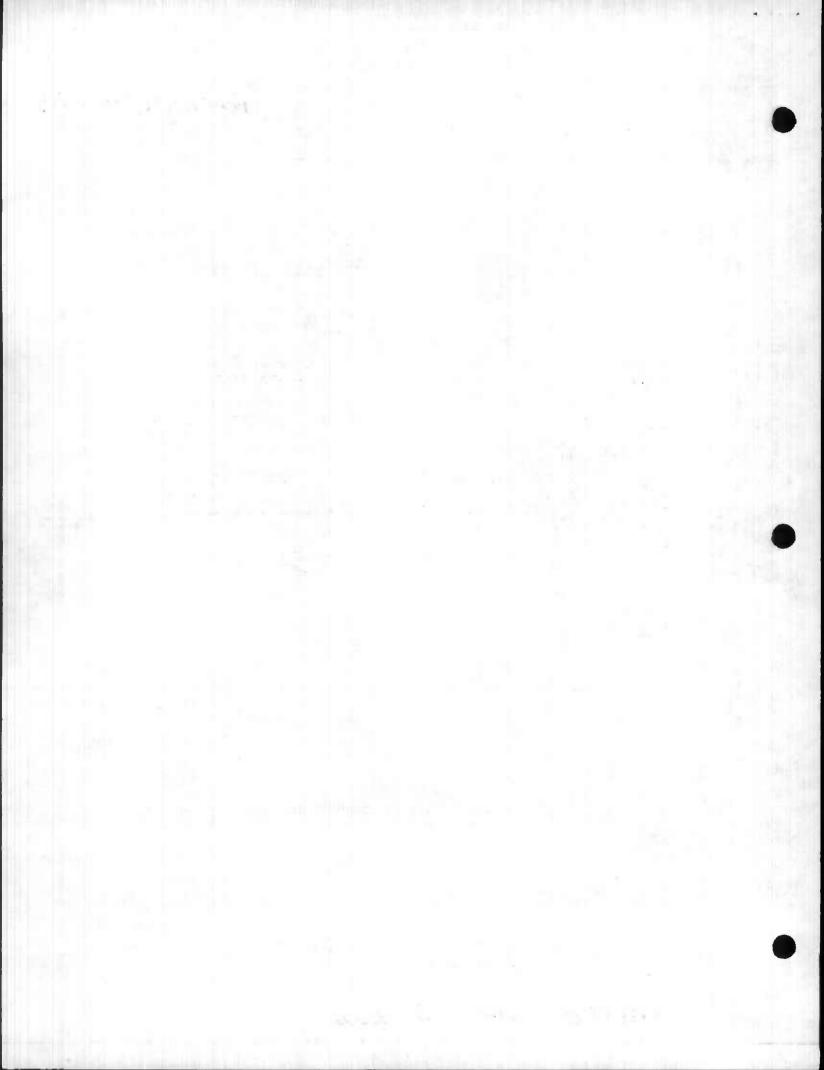
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21205

cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Sol

crseber 32, Registrer's Signature

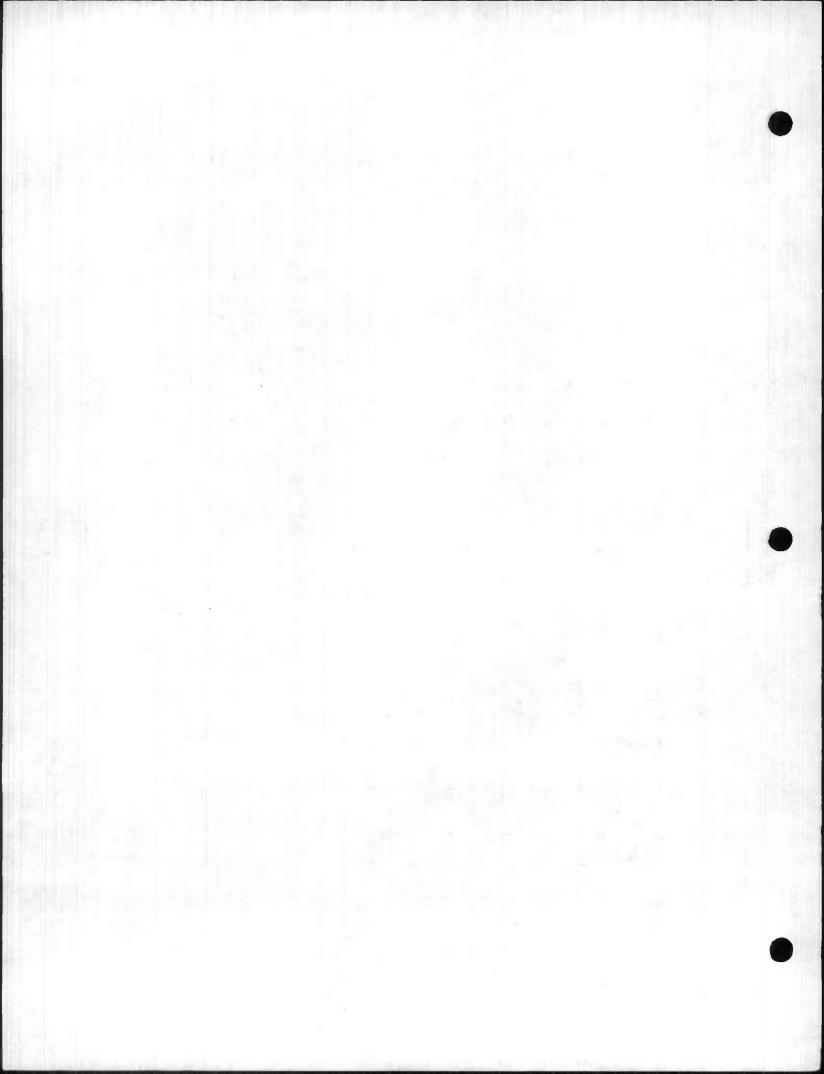
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State of Maryland / Department of Health and Mental Hygiene | |

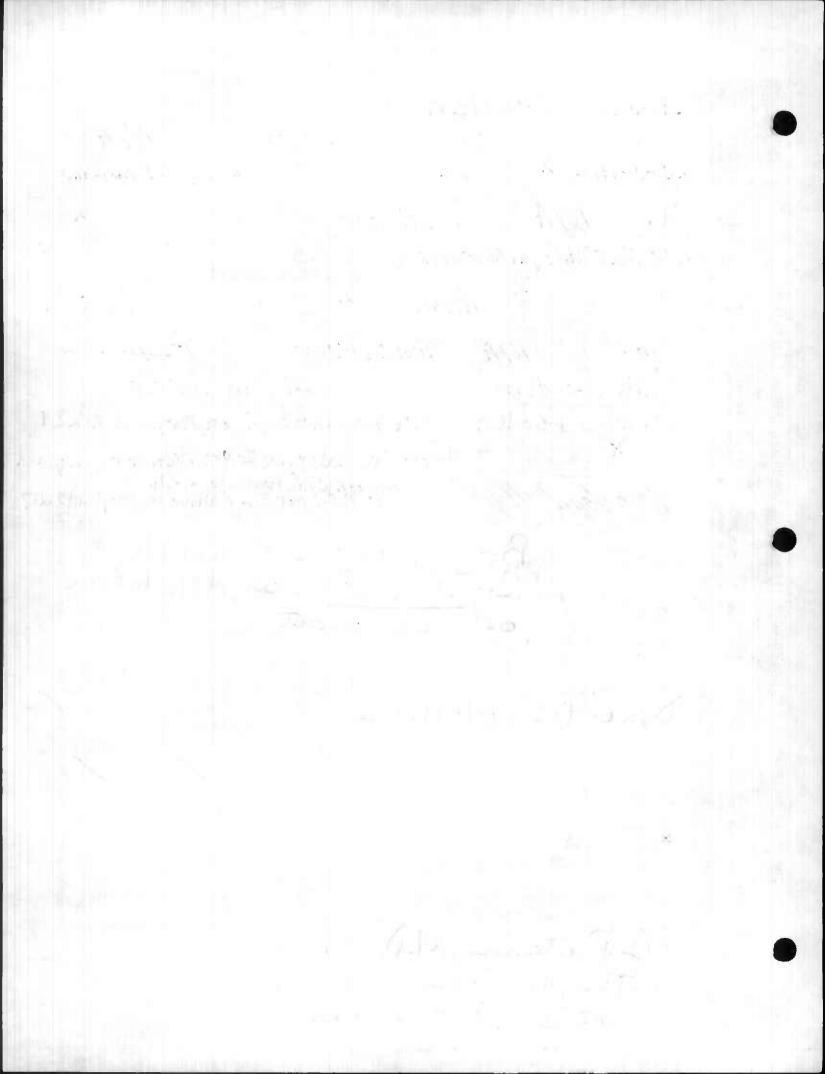
05433 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** ANTHONY V LUTRZYKOWSKI SR. 15 2000 FEB 11:45am /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Nursing Home Dunda1k Baltimore If Under 1 Yaar If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours Yrs. 213-01-3457 86 Director Oct 10 1913 MAryland Usual Residence of Decedent the Meryland 10a Steta 10h County 10c. City. Town or Location 10d. inside City Limits than "natural", or items 23s or 28s-f show the Medical Essentiver must be notified at Md Baltimore Middle River 1 ☐ Yes 🎾 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 Essex Square 21220 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 21© No If Yes, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Merital Stetus Bleck, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 € No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Maintenance Man Baltimore City 7th other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth and Mental H lamt; If item 27 is marked out Be Anthony Lutrzykowski Lucy Paszkiewicz 19e. Informent's Neme/Relationship (Type, Print) 19b. Melting Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Anthony Lutrzykowski Jr / son 900 Mace Ave. Baltimore Md. 21221 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta Burlal 2 Cremation 3 Ramoval from Stata 6 Department of Important; If any Injury or DACE. SacredHeartOf Jesus 2/17/2000 Baltimore Md. 21. Signeture of Funaral Sarvice Licenses 22. Neme end Address of Facility Connelly Funeral Home of Essex 23e. Pert 1. Enter the disease, or complications that caused the deeth Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure, that only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disaese or condition resulting in deeth) Examiner Examiner and the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Lasi physician Physician/Medical Due to (or as a consequence of): attending 980 ŏ Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. ed by the e P.0. 23b. Did tobacco use contribute to the cause of deathsigned by t 1 Yes 2 No 3 Probably 4 Onknown Records, þ 24b. Were autopsy findings aveilable prior to completion of causa of death? 24a. Wes an autopsy performed? Completed has certificate 1 Yas 20 No 212 No Division of Vital 25. Was case referred to medical axaminer?
1 Yes 2 160 director, Be 26. Place of Death (Check only one) Hospitel: 252/No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 3D DOA 2 ☐ ER/Outpatient this funeral 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how triury occurred Certification: 28c. Injury at Work? 1 Netural 5 Pending investigation I or Attending after death. Director: After 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide filled in 24 hours a Funeral D 29e. Certifier (Check only one) edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. To the within 2 29b. Signature and title of certifier Local 1427000 address of person who completed cause of deeth (Item 23e) (Type, Print) MARGICAMP 12°C0 32. Registrer's Signeture 2 2000 State Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 4 3 4

| | Certificate | of Death | Reg. No. | 0 03434 | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------|--|--|--|
| Physicia | Decedent's Name (First, Middle, Last) | | 2. Dete of Death Month Day | 3. Time of Death | | | |
| /Medica | AMOS LOUGEN | | FEBRUARY 17, | 2000 4:02 P.M. | | | |
| Examine | | 4b. City, Town, or Loc | | hty of Death | | | |
| | | Baltimos Year M Under 24 Hrs. | , | 9 Rightplace (State or Foreign | | | |
| Funeral Director | 5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. Worths Usual Residence of Decedent | Days Hours Min. | 8. Date of Birth (Month, Day, Year) April (15) 1927 | 9. Birthplace (State or Foreign Country) MARYLAND | | | |
| 1 21215-0020 led within 72 hours effer deeth with the Maryland byglene. her than "naturel", or items 23s or 28s-1 show it, the Historial Pamping must be notified at Completed by Funeral Director | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits | | | |
| | BIND N/A Baltimor | | | 1 Yas 2 □ No | | | |
| | | ode | 10g. Citizen o | of What Country? | | | |
| | 11. Marital Status 12. Wes Decedent Ever in U,S. 13. Wes Decedent | nt of Hispanic Origin? (Spec | cify Yes or No- | lace - American Indien, | | | |
| | | y Cuban, Mexican, Puerto F | Rican, etc.) B | lack, White, etc. | | | |
| | 2 3 Wildowed 4 Li Divorced Year or Dates: / 4 / 1/2 / 1/2 / | No Specify: | Spec | American | | | |
| | 15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work | Occupation done during most of workin retired) | 16b. Kind of | Business/Industry | | | |
| | Elementary/Secondary (0-12) College (1-for 5+) Truck Dr | iver | Trans | portation | | | |
| be filed dother avant, is | 17. Father's Name (First, Middle, Last) | | (First, Middle, Maiden Sum | | | | |
| | Ollie Louden | Li11/16 | in Tolive | 25 | | | |
| | | ~ 0 | Route Number, City or Tox | m, State, Zip Code) | | | |
| | | | more Maryle | und 21229 | | | |
| O 85=2 | 1 Burial 2 Cremation 3 Removel from State | er plece) | 10 711 | n - City or Town, Stata | | | |
| nit. Pe | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and | Address of Facility | A . | more, Maryland | | | |
| Ba Pem Dependent | Ana la MMM - Albert | P. Wylle Fune | ray Home V. A. | n I lang | | | |
| | 23a. Part1. Enter the disease, or completeline that caused the death. Do not enter the mode shock, or heart feiture. List only one cause on each line. | of dying, such es cardiac o | respiretory errest, | Approximate | | | |
| Physician | snock, or near reliure. List only one cause on each line. | 1 | . 11 | Intervat Between Onset and Death | | | |
| /Medical Examiner | Immediate Cause (Finet disease or condition | tasis | with | ^ | | | |
| | resulting in death) | | 0 - 1 - 0 | 1 | | | |
| B 4 | Sequentially list conditions, if any leading to immediate cause Enter I before the design. | ricular | - dila | railin | | | |
| 60, be assouted lolen end burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | |
| | Cause (Disease of Injury C. That in favore a conception of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Con | | | | | | |
| riffice ng ph | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | |
| Cords, P.O. Box 6 v requires that the death cardiff been signed by the attending s ahould be detached for use as | d. Part It. Other significant conditions contributing to death but not resulting in the underlying could be about 4.4 | | | | | | |
| O the de de de de de de de de de de de de de | Part It. Other significant conditions contributing to death but not resulting in the underlying ceu | ise given in Pert I. | 23b. Did tobacco use contribute to the cause of death? | | | | |
| P.O. thet the detached detached | Diabetes Mellitux | • | 1 Yes 2 No 3 Probably 4 | | | | |
| Records, | | | 24e. Was an autopsy | 24b. Ware autopsy findings available prior to | | | |
| | | | performed? | completion of cause of death | | | |
| He te page | | | 1 Yes 2 □ No | 1 € Yas 2□ No | | | |
| Vital Re- | 25. Was case referred to medicat | 26. Place of Deeth | (Check only one) | | | | |
| 수 등 | Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA | | ne 5⊠ Residence 8 □0 | | | | |
| C 2 2 2 | | | | | | | |
| Division or Attending after death. Director: After in by the fune | 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, | 1 Yes 2 No | Rf. Location (Street and Nu | mber or Rural Route Number, | | | |
| Div A shar din bin bin bin bin bin bin bin bin bin b | 27. Manner of Death Matural 5 Pending 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28c. Place of Injury - At home, farm, street, fectory, building, etc. (Specify) | ,,,,,, | City or Town, State) | | | | |
| | | | | | | | |
| the Hk lin 24 the Fu | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated. | | The second second | | | | |
| 01400000000000000000000000000000000000 | IND T | License number | 29d. Date sig | ned (Month, Day, Year) | | | |
| 6 | 7 | .C.M.E. | FEBRUA | ARY 18, 2000 | | | |
| V | 30. Name and discourse of person who completed cause of death (Item 23a) (Type, Print) OR CON PS Fame v 111 Pen | n Street Ra | ltimore, Mary | aland 21201 | | | |
| State | 31. Date legs (Month, Day, Year) 32. Registrar's Signature | | range, raty | LAN CIEVI | | | |
| Registra | | alle | | | | | |

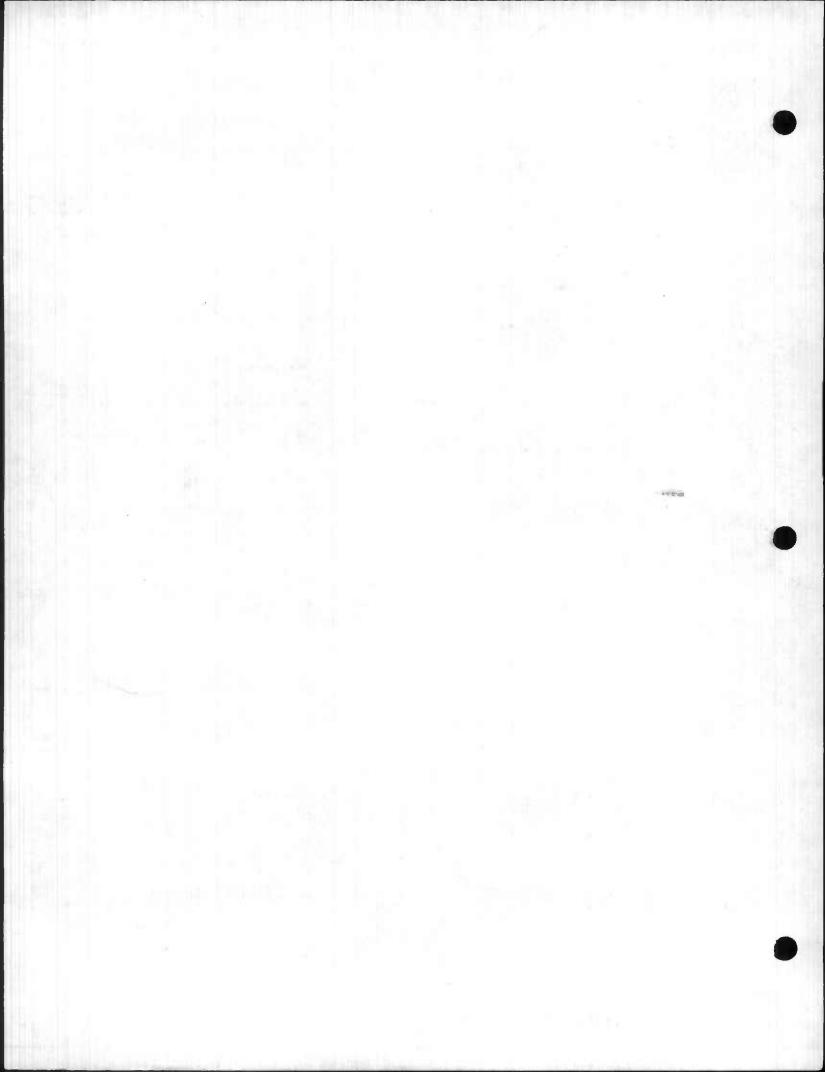


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| State of Maryland / Departme | ent of Health and Mental Hygiene 🕦 🗍 | 1 |
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| DODEDE | Last) | | | f Death Reg. No. 2. Dete of Death 3. Time of Death | | |
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| Decedent's Neme (First, Middle, Last) ROBERT LOWT | | | Month | | Month Day Year | |
| 4e Facility Name (If not institution, | give street and number) | LOWI | 4b. City, Town, or | | 4c. County | |
| THE JOHNS HOPKI | NS HOSPITAL | | BALTIMORI | E CITY | no | one |
| | Sex 7. Age (in yrs. i. | ast birthday) If Under 1 Y Yrs. Months Di | ear If Under 24 Hrs. ays Hours Min. | 8. Dete of Birth (Month, Day December | , Year) | 9. Birthplace (State or Fore Country) NORTH CARolina |
| 10a. Stete 10b. County | 10c. City | r, Town or Location | | | | 10d. Inside City Lin |
| MARyland nor 100. Street and Number | ie 15A1 | timore | | | | 1 (Yes 2 □ |
| 10e. Street and Number | / | 10f. Zip Co | | 1 | Og. Citizen of V | |
| 11. Meritei Status | 12. Wes Decedent Ever in U, | 2/2 | | nacify Vac or No. | USA 14 Baci | e - American Indian, |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | Armed Forces? | tf Yes, specify (| of Hispanic Origin? (S Cuban, Mexican, Puert , No Specify: | o Rican, etc.) | Specify | k, White, etc. |
| 15. Decedent's | Education | 16a. Decedent's Usual Or | cupation | dia | 16b. Kind of Bu | |
| (Specify only highest Elementery/Secondary (0-12) | College (1-4or 5+) | , , | one during most of wor stired) | King | . / | |
| 844 | none | Labore | | 700 - A41 A 10 | Seif | |
| 17. Father's Name (First, Middle, La | | | 18. Mother's Ner | ne (First, Middle, | , , | Θ) |
| 19e. Informent's Neme/Reletionship | There Print | 19b. Mailing Address (St | CIORET | | 1/1/US | State 7in Codel |
| | Wher - Hother | 232 Douglass | | | | |
| 20e. Method of Disposition | 20b. Pl | ece of Disposition (Neme of | d I | Date | - | City or Town, Stete |
| Buriel 2 Cremetion 3 4 Donetion 5 Other (Spe | LIBernovel from Stete | shells Gande | | 124/2000 | Dunda | LR, HARylan |
| 21. Signeture of Funerel Service Lic | | 22. Neme and A | ddress of Fecility / | marin (| In Ilnes | FUNERIH (SERVI |
| Mayor m. | Plancas | 3405 W, | FRANKLIN ST | L. BAHING | ire, mar | eyland 21229 |
| disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Indexturing | , | es a consequence of): | | | | NOT KNOWN |
| | | CANCER TITEL | | | | |
| Sequentially list conditions, if any, leading to immediate | D | CANCER WITH as a consequence of): | OBSTRUCTIO | ON OF BRO | ONCHUS | NOT KNOWN |
| Cause (Disease or Injury that initiated events | Due to (or | as a consequence of): | OBSTRUCTIO | ON OF BRO | ONCHUS | NOT KNOWN |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest | Due to (or | DUTCH SEC 1984 | OBSTRUCTIO | ON OF BRO | ONCHUS | NOT KNOWN |
| that initiated events | Due to (or | as a consequence of): | OBSTRUCTION OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF | ON OF BRO | ONCHUS | NOT KNOWN |
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| resulting in death) Lest | Due to (or Due to (or | as e consequence of): es e consequence of): | | 23b. Did to | | |
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DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | \(\cap \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20 2104 BETTY E. LAMBERT 4a Facility Name (If not institution, give street and number) Ac. County of Death 4b. City, Town, or Location of Death FALLSTON GENERAL HOSPITAL FALLSTON If Under 24 Hrs. HARFORD If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1□ M 2₩ F Months Days Hours Yrs. 212-30-0953 11/14/32 MARYLAND 67 Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD HARFORD **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1841 JOHN DRIVE USA 14. Race - American Indian, Black, White, etc. 21040 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12TH GRADE DEPARTMENT MANAGER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) LAWRENCE GROFT HELEN SHAFFER 19a, Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES E. RUBY SON 1884 OXFORD SQUARE BEL AIR, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 Grantial 2 Cremation 3 Removal from State WESTMINSTER CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2/24/2000 WESTMINSTER, MD 21. Signature of Fungral Service Licensee 22. Name and Addrass of Facility THE JOHNSON FUENRAL HOME, P.A. 23. Part First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximat Intervel Between Onset and Death tramediete Cause (Final disease or condition resulting in death) SEPSIS 15 PAYS Due to (or as a consequence of): LYMPHOMA, LARGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HEPATOMA 1 Yes 2 10 3 Probably 4 Unknown PRIMARY BILLARY CIRRHOSIS 24b. Were autopsy tindings 24a. Was an eutopsy available prior to completion of cause of death? 1 Yes ZUNO 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner Physician/Medical

Physician

/Medical

Examiner

Director

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Saltimore, Maryland 21215-0020

or Attending Physician: deeth. after To the Hoepital o within 24 hours at To the Funeral Di completely filled in

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Completed

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edical Certification:

AMBERT

10 Registrar 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. few NOndlenst ins

28a. Date of Injury (Month, Day Year)

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D08096

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

February 21, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

ANDRON NONACCOUSE USD

125 M. MAIN ST. BELAIK, MP21019

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Magner of Death

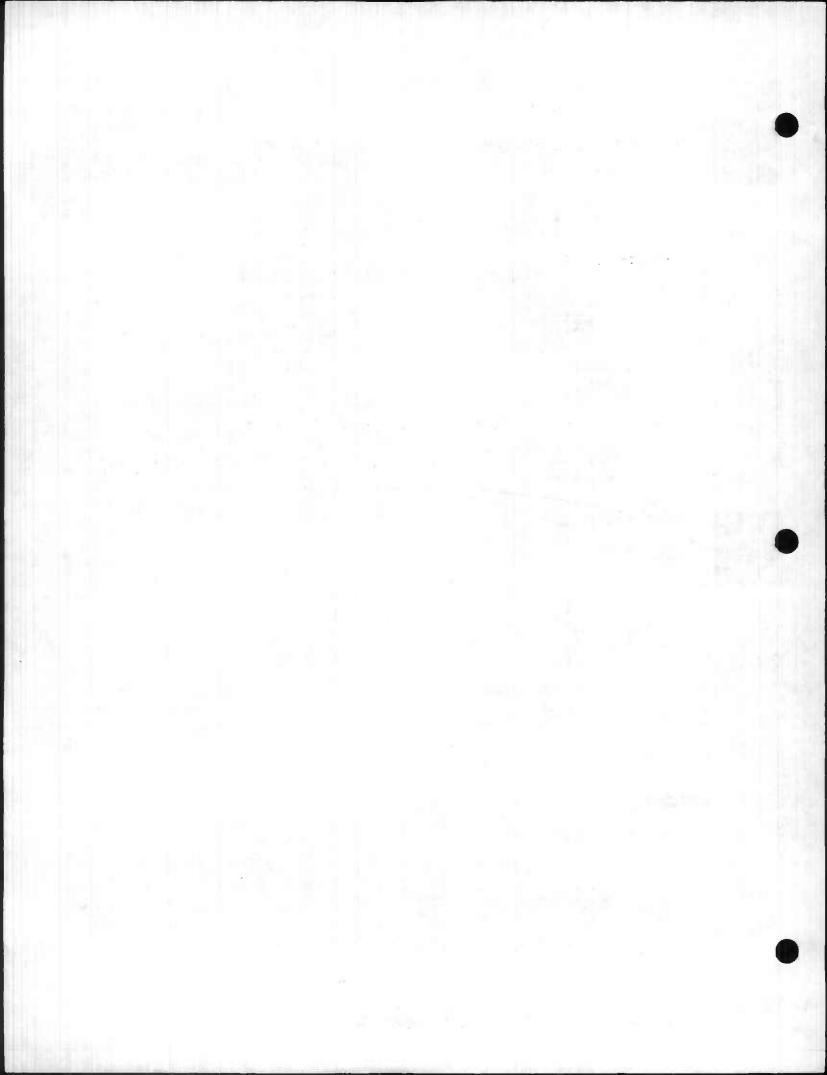
1 Natural
2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

32. Registrar's Signature



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 2. Data of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** :09am COOS Planar /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital nerou If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 1-7-1934 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Months Days Hours Min. 1 M 2 X F Baltimore, Maryland Yrs. 66 215-30-6641 Usuel Rasidence of Decedant 10a. Stela 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director MD n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3602 E. Pratt Street 21224 USA Funeral 12. Wes Dacedent Evar in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Detes: 1 1 Never Married 2 ☐ Merried Specify: White 1 ☐ Yes 2 X No Specity: by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) Church Elamantary/Secondery (0-12) College (1-4or 5+) Our Lady of Pompei Domestic Engineer 12th 18. Mothar's Neme (First, Middla, Maidan Sumeme) 17. Fether's Neme (First, Middle, Last) Waneita Cunningham Barthomew Lane 19e. Informent's Name/Raletlonship (Type, Print) Sister 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B602 E. Pratt Street, Baltimore, Maryland 21224 Betty Lane 20b. Placa of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 2/22/2000 Baltimore, Maryland Oaklawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Joseph N. Zannino Jr. Funeral Home 21. Signature of Funerel Service Licenses 263 South Conkling Street, Baltimore, Maryland 21224 arra ions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximete Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused to shock, or haart failure. List only one cause on each line Immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or as a consequence of): Examine Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury Due to (or es e consequença of) Physician/Medical thet initiated evants rasulting in deeth) Lest Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Junknown þ 24b. Wara autopsy findings aveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of daeth? 2000 1 ☐ Yes 2 000 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Inpatient 1 Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Panding Investigation 1 Tyes 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 29e. Certifian 1 Certifying Physician: To tha best of my knowledga, daeth occurred et the time, date end plece, and due to tha causa(s) end manner as stated. edical 2 Medical Examinar: On the besis of examination end/or invastigetion, in my opinion, deeth occurred et the time, date end place, and dua to the cause(s) and mennar stated. (Check only one) S 29b. Signeture and title of cartifier 29c. License number

State

Funeral

Director

ir than "natural", or itema 23a or 28a-f ahow the Madical Examiner must be notified at

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the Maryland

death ,

e filed within 72 hours after al Hygiene. other than "natural", or ite

12 should be fi and Mental H Is marked off

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once.

Physician

/Medical Examiner

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signed by

Pass **DBDB 2**

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Ahar Attending

after death Director:

To the Hospital within 24 hours To the Funeral I

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Box 68760 ficate be

P.O.

Division of Vital Records.

Baltimore, Maryland 21215-0020

Registrar

DHMH 16 Rev 6/95

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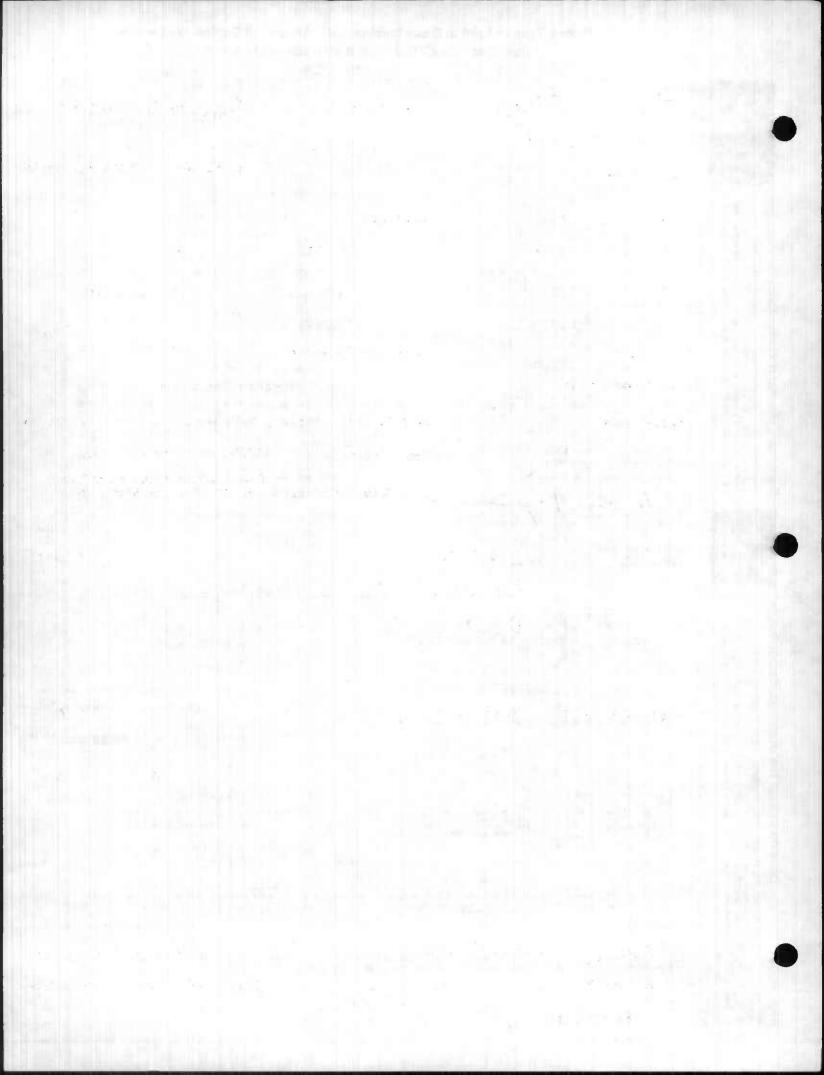
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31. Dete filed (Month, Dey, Year)

cause of deeth (Itam 23e) (Type, Print)

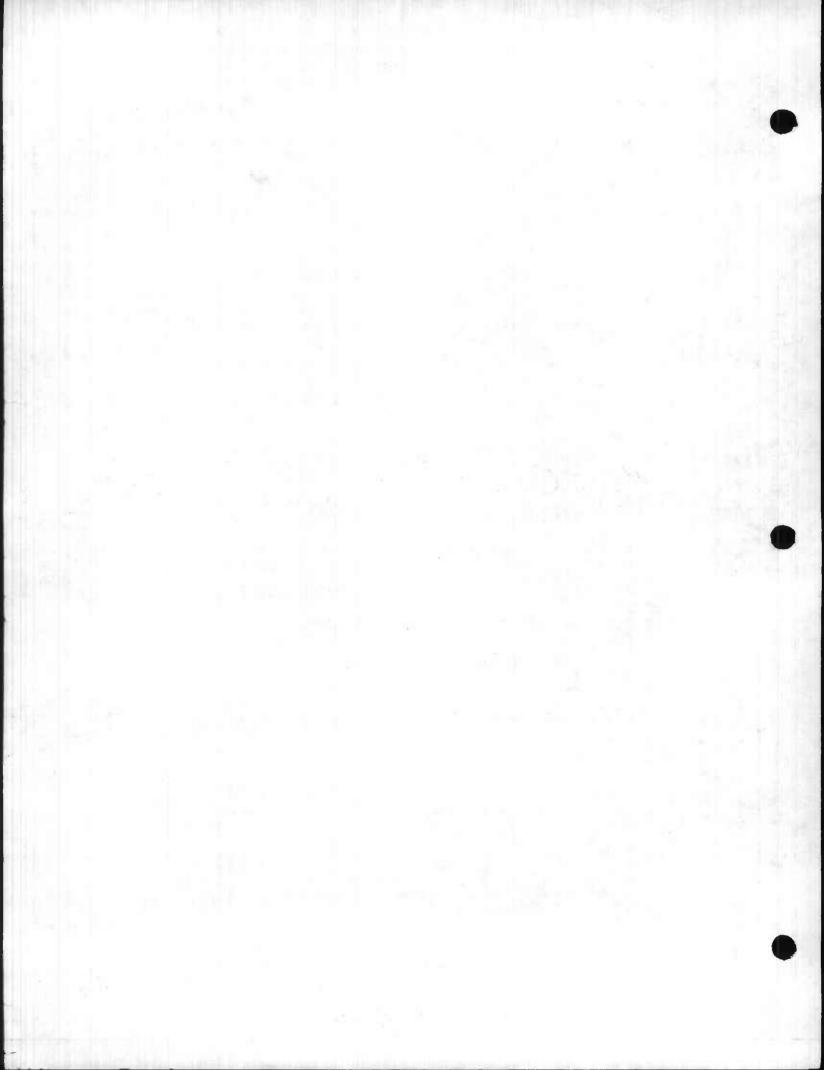
32. Registrer's Signature

29d. Dete signed (Month, Dey, Year)



DHMH 16 Ray 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Physical Death Physical Death Print Middle, Last) 3. Tima of Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical Death Physical De

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| | Physician /Medical | MARY ELIZABETH | MAPP | PEB PAS 2900 1556 |) |
| 9 | Examiner | 4a Eacility Name (If not institution, give street and number) STAGNES HEALTHOAR | E BALT | cation of Death 4c. County of Death | |
| | Funeral Director | 5. Social Security Number 6. Sex 1 M 29 F 53 | Months Days Hours Min. | 8. Data of Birth (Month, Day, Year) (Month, Day, Year) GBRUARY 201946 NORTH CAROLINI | 1 4 |
| | show stow | | Town or Location | 10d. Inside City Limits | |
| | with the Marylar a or 28s-f show | MARYLAND NA BA | ITIMORE CITY 101. Zip Code | 1 1 √ Yas 2 No | |
| | th with | | 21229 | U.S.A. | |
| | r tems 23 direc must | 11. Meritel Status 12. Was Decedent Ever in U.S. Armed Forcas? | 13. Wes Decedant of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puarto | ocify Yes or No- Rican, atc.) 14. Race - American Indian, Black, White, atc. | _ |
| 000 | DV V | 3 ☐ Widowed 4 ☐ Divorced Yeer or Datas: | 1 ☐ Yas 2 ☑ No Specify: | Specify: BLACK | |
| 21215-0020 | ed within 72 ho ygiene. wr then "neturn rt, rre Hrafeel Completed | 15. Decedent's Education (Specify only highest grada completed) | Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) | 16b. Kind of Businass/Industry | |
| 212 | 2 should be filed with and Mental Hygiene. Is marked other than aurratic event, tree! To Be Comp | Elementery/Secondary (0-12) Collega (1-4or 5+) | NURSE ASSISTAN | UT NURSING AGENCY | |
| 5 | should be filed and Mental Hygi marked other imatic event, To Be Co | | | (First, Middle, Maiden Sumama) | |
| ylai | Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta | JACKSON W. BAI | RNES CLARII | NE WATSON | |
| Maryland | 2 should and Men is marke sumatic | 19a. Informant's Name/Retationship (Type, Print) | 19b. Mailing Addrass (Street and Number or Rura | | |
| | | | 4437 PENLUCY ROAD | BALTIMORE, MD 21999 | |
| ore | Pages 1 nent of Ha nft: If Ren iry or oth | 20a. Method of Disposition 1 Method of Disposition 20b. Plac cem | ce of Disposition (Nema of natary, cramatory or other place) | Data 20c. Location - City or Town, Stata | |
| E | Pag ment ant: luny | | RISON FOREST VI | 1-28-00 OWINGS MILLS, MD, | 1999 190, 6 217 ata ata ata ata ata ata ata ata ata at |
| Baltimore, | permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. | 21. Signal moof Funaral Sarvice Licensee | 22. Nama and Addrass of Facility JOSEPH H. BROWN | JR. FUNERAL HOME E., BALTIMORE, MD 21217 | > |
| | | 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. | | | - |
| | Physician | | | Onset and Deeth | |
| | /Medical | Immediata Cause (Final disease or condition | cinoma with Distort | Metastasis 1985- | |
| | Examiner | | s a consequence of): | 1616378313 | _ |
| A. | N 4 di | b. Sepsis | | One Week | |
| 20 | n and sal-transit Examiner | | s a consequence of): | | |
| 60, | | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that inflated events | e Heart Failure | Unknown | |
| 09289 | physical s the bu | that initiated events resulting in death) Last | s a consequence of): | | |
| × | 2 5 E | d | | | |
| 0 8 | at the death of the amend efacthed for us Physicians | | | | |
| 0 | the d | Part II. Other significant conditions contributing to death but not resulting | ng in tha underlying causa given in Part I. | 23b. Did tobacco use contribute to the cause of death | |
| 40 | | | | 1 Yes 2 No 3 Probably 4 Unknow | 'n |
| Sproo | The law requires to cate has been signs page 2 should be completed by | | | 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause | |
| (1) & | a lay | | | of death? | |
| 页 | Theate | | | 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☑ No | |
| >5 | sician: certific insciori o Be | 25. Wes cesa referred to medical axaminer? 1 Yas 20 No Hospital: 10 Inpatient 2 FR | 26. Place of Deeth Other: 47 Alumina Ha | | _ |
| 20 | F 50 P | 7 | VOotpatient 3LI DOA 4LI Norsing Hor | ma 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred | |
| A . | Allor Hun | 1 Natural 5 Panding (Month, Day Year) 2 Accident Invastigation | Injury Work? M 1 Yas 2 No | | |
| Sivis | to after death. In after death. In Director: After 1 ad in by the funera Certification: | 3 Suicide 6 Could not be datarmined 28a. Plece of Injury - At home building, atc. (Specify) | a, farm, streat, factory, offica | 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) | |
| NAME | he Hospital in 24 hours he Funeral pletaly titled edical Ce | 29a. Cartifliar (Check only 2 Medical Examiner: On the basis of axaminetion | odge, deeth occurred at the time, date and place, on and/or investigation, in my opinion, death occurred | and due to the cause(s) and menner as stated. But and place, and due to the cause(s) | |
| N | # 2 # E ** | one) and mannar stated. 29b. Signatura and title of certifiar | 29c. Licensa number | 29d. Data signed (Month, Day, Year) | |
| - | 5150 | NO DO | 211700 | | |
| - | 6 | John F. Clonner M | 1.0 P/1/00 | February 18, 2000 | |
| | 9 | 30. Name and address of person who complated cause of death (Item 23 | A) (Type, PINT) | Itimore MD | |
| | State | 31. Data filed (Month, Day, Year) 32. Registrar's Signature | | TIMBIE IIIN | _ |
| | Registrar | FLB 2 2 2000 Berry 12 | sports | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death 8:00PM MCCORMICK VERIA ANN 02 20 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 123 FLEMING DRIVE TURNERS STATION BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Deys 1 M 20 F Yrs. 220-24-0323 88 1911 Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. tnside City Limits BALTIMORE 1 Yes 2 □ No TURNERS STATION 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 FLEMING DRIVE 21222 USA 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Merried t ☐ Yes 2 No Specify: Specify: BLACK 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 5 DOMESTIC HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) WALTER GADDY ANNIE MEADOWS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) ROBERT ANN MC CORMICK 891 GITTINGS CT. ABINGDON, MD. 21009 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stela cemetery, crematory or other place) ↑ Burial 2 Cremetion 3 Removal from Stete 4 ☐ Donalion 5 ☐ Other (Specify) ARBUTUS MEM. 2/25/2000 BALTO., MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC mes 1701 LAURENS ST. BALTO., MD. 23a. Part / Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final months disease or condition resulting in death) Due to (or as a consequence of): 5-10 years ementic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thiury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury al Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

Completed by Physician/Medical Examiner The law requires that the death certificate be executed **burdel-transit** pue Box 68760. tha Division of Vital Records, P.O. this certificate has funeral director, Be Certification: To After

after death.

I Diractor: Aft
I by the fur

Physician

/Medical

Examiner

MD

Director

Funeral

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ir than "natural", or itema 23a or 28a-f aho

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene.

By Inportant: If itam 27 is marked other then "natural", or Nen any Injury or other treumatic avent, the Medical En

Physician /Medical

Examiner

21215-0020

altimore, Maryland

or Attending Physicien: To the Hospital of within 24 hours at To the Funeral D completely filled I

> State Registrar

DHMH 16 Rev 6/95

edical

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

3 ☐ Suicide

29a. Certifier (Check only one

4 Homicide

6 Could not be

Kaffenbarger,

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

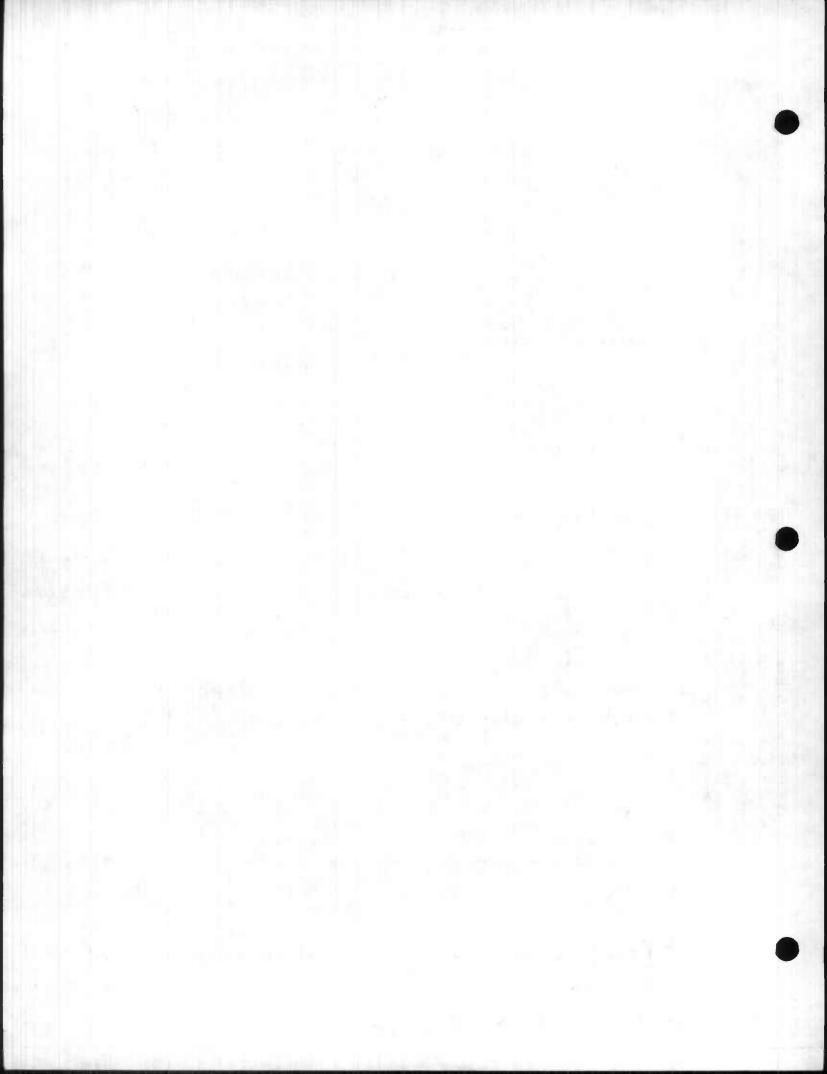
ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D00516.

5505 Hopkins Bayview Circle, Baltimore, MD 21224



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05441 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** GEORGE MONATH SR. A FEBRUARY 18,2000 08:55 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson 5. Social Security Number If Under 1 Yeer If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 7 1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sax **Funeral** Months Deys Hours 15 M 20 F 219-16-9940 76 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Middle River MD **Baltimore** 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 13218 Cherwin Ave. 21220 USA Examiner must death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 ☐ No If Yas, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 No Specify: White Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Plumber Plumbing 11th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John G Monath Helen Gumpman 9 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marie Monath / wife 13218 Cherwin Ave. Baltimore Md 21220 20b. Plece of Disposition (Neme of cemetery, cremetery or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Holly Hill Cemetery 2/21/2000 Baltimore 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Neme end Address of Fecility Connelly Funeral HOme of Essex 300 MAce AVe. Baltimore Md 23a. Pert1. Enter the disease, or complications that caused the dualth / Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feiture. List or you cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 1 MONTH LUNG CANCER, SMALL CELL **Examiner** Due to (or as a consequence ot) Physician/Medical Examiner The law requires that the death certificate be executed **burial-transit** Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence ot): 68760 phys the Due to (or es a consequença of) Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tas 2 No 3 Probably 4 Unknown d be det CHRONIC OBSTRUCTIVE LUNG DISEASE Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy 1 Yes 2 1 No 1 Yes 2 No Vital Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of 27. Manner of Death 28e. Dete of tnjury (Month, Dey Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Netural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier edical å 29d. Date signed (Month, Day, Year) 29b. Signature and jille of certifie 29c. License number D31189 00

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

MICHAEL

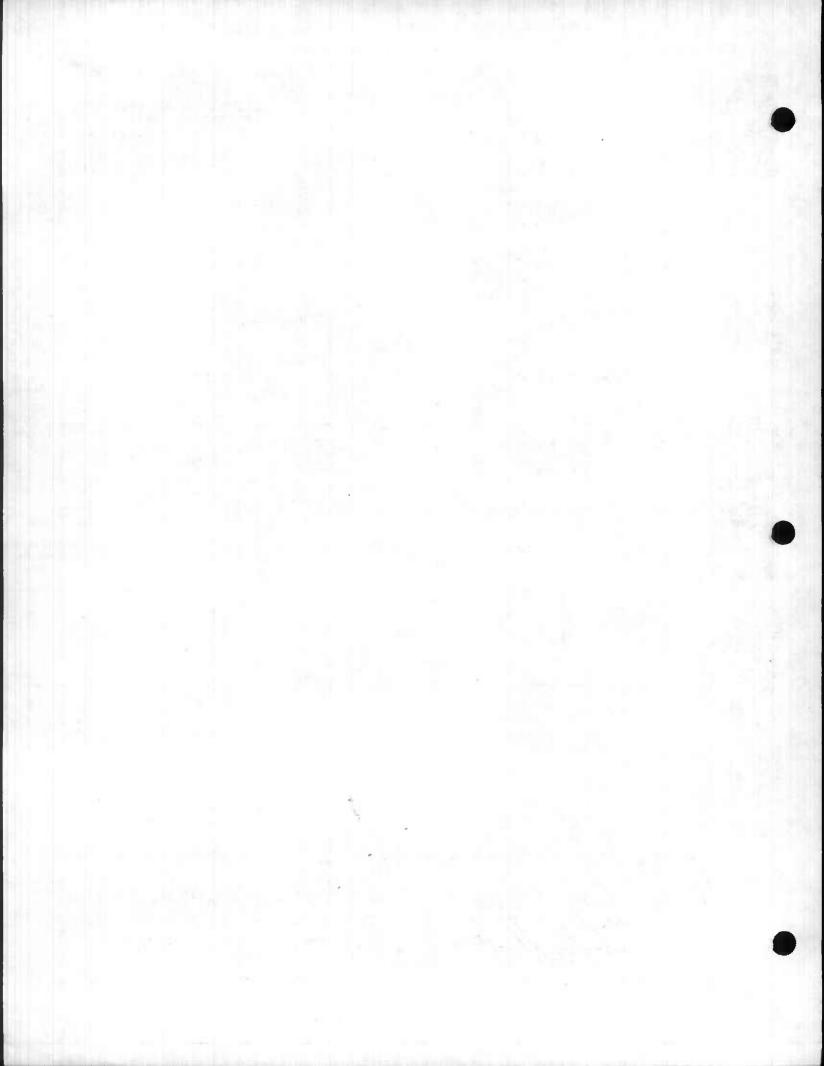
32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. MININSOHN M. D.

B. Spork

8813 WALTHAM WOODS ROAD, BALTIMORE MD. 21234

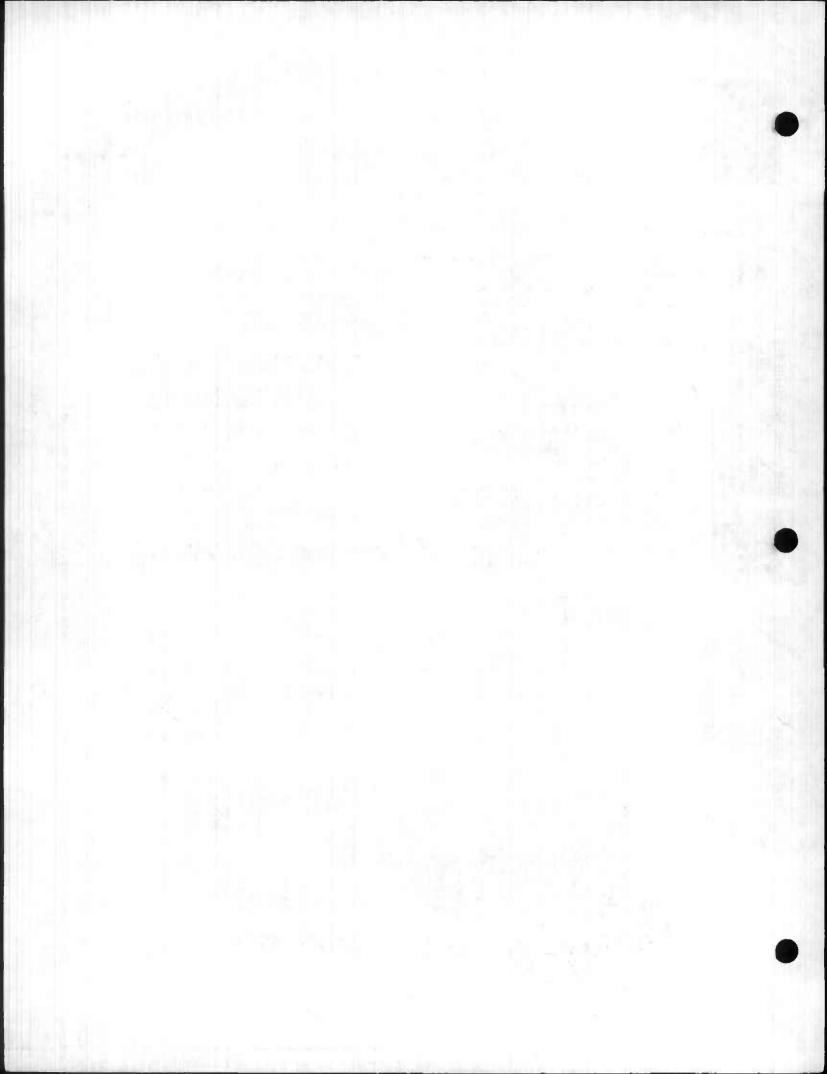


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Physician VM. McCrea Anna : 10Am 4b. City, Town, or Location of Death 8,2000 /Medical 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore Hartor 019 If Under 24 Hrs. Hours Min. If Under 1 Year Months Days Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dala of Birth (Month, Day, Year) **Funeral** Days 1□M 20 F -82-672 Director Sept. 16,1926 New Usual Residence of Decedent the Maryland 10a. Stale 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 20 No RaltImore Director 288-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be b 3 2 .A ar tord Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Hygiene. Oher than "natural", or Item ent, the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 25(No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Jomes Homemaker 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Iham 27 is marked of any Injury or other traumatic eve Barber John Andrew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harford Rd. Baltimore, mi Mr. George H. McCrea-Spuse 20a. Method of Disposition | 20b. PI 2 019 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Data Elb 18 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Funeral Chapel-Bolding Forest Hill, Mayland 2000 21. Signature of Funerat Service Licenses 22. Nama and Address of Facility Evans chapel of memorial 8800 Harford Rd. Baltmore, mD 0 12 Approximata Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or as a consequence of) US0 85 Division of Vital Records, P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yes 2 2 No 1 ☐ Yas 2 No or Attending Physician: director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yas 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this sid funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation 1 ⊠Natural 2 ☐ Accident within 24 hours after death.
To the Funeral Director: Al completely filled in by the fu 1 TYes 2 TNo 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Light of the cause(s) and mannar as stated.

Light of the cause(s) and the time, data and place, and due to the cause(s) 29a. Cartifie ner: On the basis of axa and manner slates one) 94 Pay, Year) 29d. Date signed (Month, 2 d address of person 31. Data fited (Month, Day, Year) State EB Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 5 1, 1, 3 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death McCloskey dward Henry 8:55 AM Feb-7,2000 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Heritage, Inc. Madonna Jarrettsville Hartord If Under 24 Hrs. B. Date of Birth (Month, Day, Year) Min. May 19,1921 7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociel Security Number Birthplace (Stete or Foreign Country) Days 1 MM 2□ F Months 8 Yrs. 098-14.2644 NewYork Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Hartord Forest 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 2645 Road 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□ Yes 200No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western electric Contract estimater 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Edward Henry McCloskey, Sr. Dickinson Anna 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mildred mcCloskey-Spuse 2645 Rutham Rd. 200. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Forest HillimD 21050 20e. Method of Disposition Date 20c. Location - City or Town, State Bel Air Mem. Gardens 2000 1 Buriai 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 22. Name and Address of Fecility Evans Funeral Chapel-Bel Bigi 21. Signeture of Funeral Service Licenses 3 Newport Drive Forest HillimD 21050 entral 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stete

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Menial Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

the Manyland

Physician/Medical Examiner þ Completed

Box 68760 Division of Vital Records, P.O. page 2 s TOTAL Hospital or Attending Physician:

within 44 hours after death.

To the Funeral Director: After this certification is the funeral director of in by

Medical State

physician and the burial-transit

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was cese referred to medicel examiner? Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Yeer)

Location (Street end Number or Rurel Route Number, City or Town, State)

23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown

24a. Was en eutopsy performed?

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

26. Place of Deeth (Check only one)

1 Yes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Dey, Year) FEB 2 2 2000

Due to (or as a consequence of)

Due to (or as e consequence of)

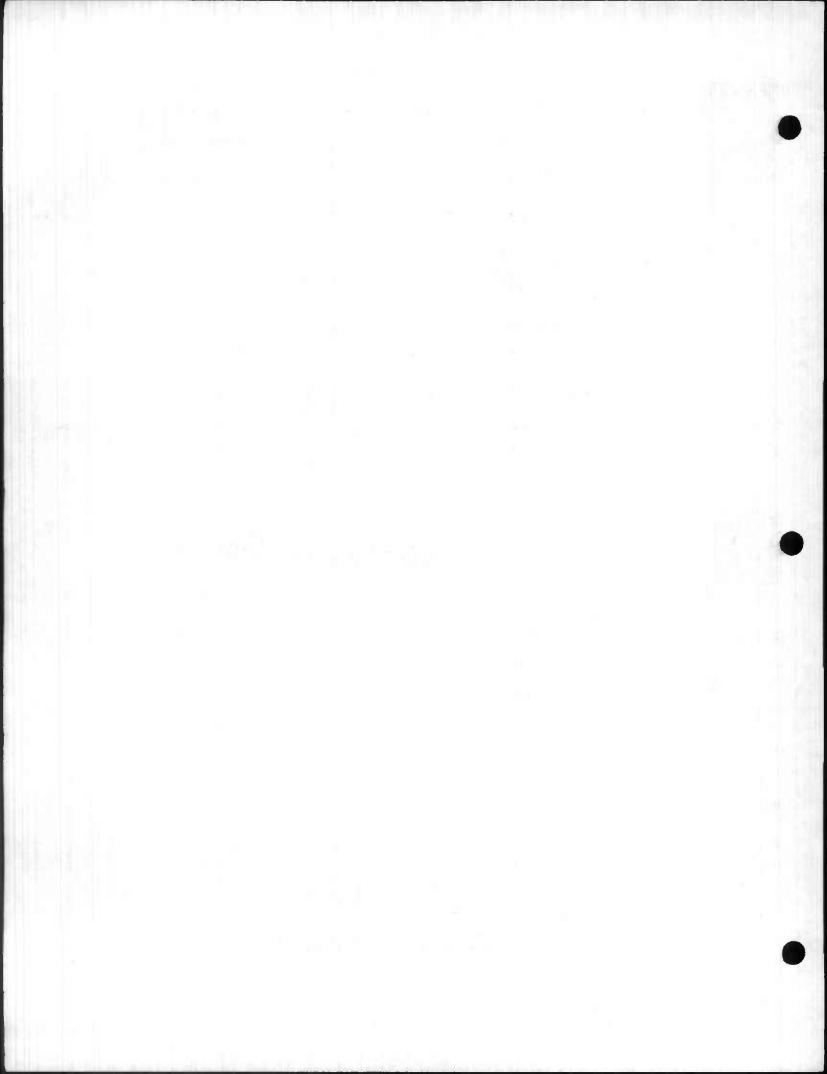
Due to (or es a consequence of):

28b. Time of

32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar



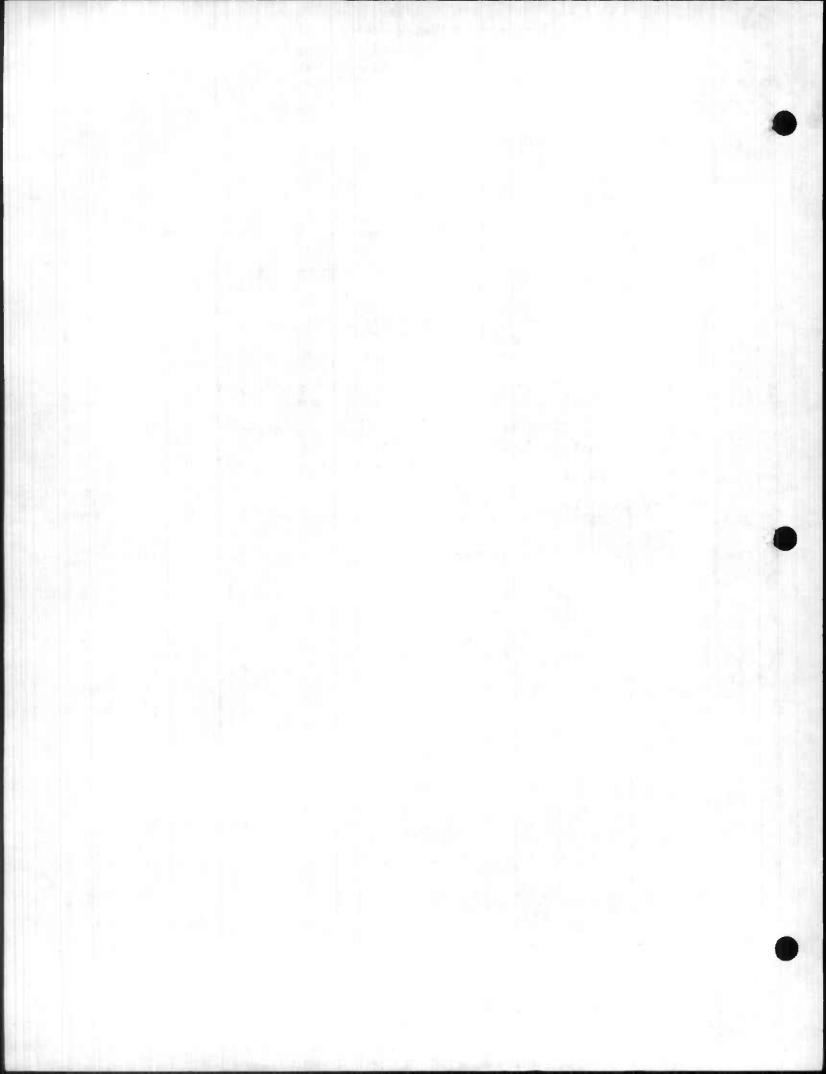
Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month Yaar **Physician** Arthur Mathes February 19 2000 4:55 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Hill Harford Birthpleca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) **Funeral** Hours Months 10 M 20 F Deys Director 051.28.0549 Oct. 18, 1900 New Usual Rasidance of Decedan death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits worle r than "natural", or items 23s or 28s-f short the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Joppa Funeral 12. Was Decedent Evar in U,S.
Armed Forces?
1 Yes 2 No
If Yas, Giva 14. Race - Amarican Indian, Black, Whita, atc. 11. Meritei Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or the 1 Nevar Married 2 Merried 1□Yas 2× No Baltimore, Maryland 21215-0020 Specify: Specify: White by 3 Widowed 4 □ Divorced Year or Detas Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Meat Processing Elamentary/Secondary (0-12) Collega (1-4or 5+) Self-employed 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be J. lenry Mathes Katharine MergardT JO-19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ratationship (Type, Print) Jean C. Mantegna-daysh. Sunshine t. Forest Hill, mD 200. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Feb. 24 Burlal 2 Cramation 3 Removel from Stata permit. Page Department of Important: If any injury or once. Maspeth, NewYork 4 ☐ Donation 5 ☐ Othar (Specify) 2000 Olivet (em 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Evans Chapel of memories Road Baltimore 8800 Harford tre 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760, Dua to (or as a consequence of): P.O. 23b. Dfd tobacco usa contributa to the cause of death? Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by t should be detach 1 Yaa 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy tindings available prior to Completed 24a. Was an autopsy performed? complation of cause of death? 1 Yas 2 No 1 Yas 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medicat axaminar? Be 26. Place of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Home 5 ☐ Rastdance 6 ☐ Othar (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending Invastigation Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 29a. Certifier Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stetad. To the Hospi within 24 hours To the Funer completely fil 29d. Data signed (Month, Day, Year) 29b. Signeture and fittle of certifier 29c. Licansa number D3227 21,2000 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) W. MACBAD. 615 5. DV 31 Data filed (Month, Day, Year) FEB 2 2 2000 32. Registrar's Signatura State Registrar

DHMH 16 Rav 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dele of Death 3. Time of Death Month Year **Physician** 12abeth Marie 26:45AM 18,2000 FEBRUARY /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Joseph Medical Center Saint If Under 24 Hrs. If Under 1 Year 8. Dele of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 M 2 KF 9226 -42-Director Usual Residence of Decedent 10a. Slala 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ahow Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Nerna 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Deles: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, Whita, etc. 11. Meritel Stelus permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If feen 27 is merked other than "natural", or ther any Injury or other traumetic event. 1 ☐ Nevar Merried 2 ☑ Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: A 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ONC 17. Father's Name /First. Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be DILBER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Neme/Relationship (Type, Print) Raymond RIVER Gloucester Middle Md Feb. 22 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Surlal 2 Crametion 3 Removel from State 2000 4 Donelion 5 DOther (Specify) aney Valley Mem. 6dns Imonium 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Evans Chapel of Memoris Harford el caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, on each line. 23a. Part1. Enter the disease, or complications that caus shock, or heart feilure. List only one ceuse on each Approximete Intervel Between Onset and Death **Physician** /Medical Immediela Cause (Finei SEPSIS disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner CIRRHOSIS OF THE LIVER physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): USB 85 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown bengis be del p Records. py The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2 NO 1 ☐ Yas 2 ☐ No Division of Vitai Be 25. Wes case referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Affer 1 Netural 2 Accident 5 Pending Invastigation or Attending after death. Director: Aft 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide 24 hours Funeral TC Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. Medical 29e. Certifie (Check only one) To the P within 2 To the P 29b. Signature and little of certifian 29c. License number 29d. Date signed (Month, Day, Year) 8 m m.C D41410 CUC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

JOGINDER P.

31. Data filed (Month, Dey, Year)

MEHTA

M. D. 7601

32. Registrer's Signature

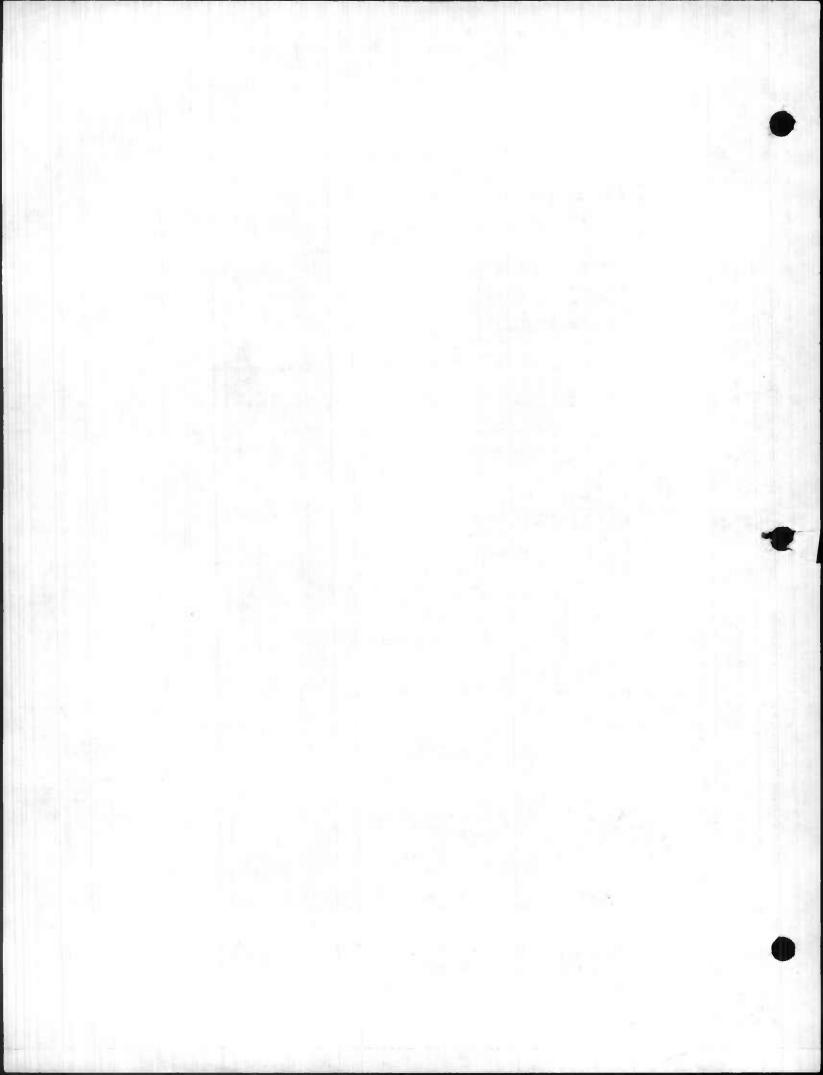
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TOWSON, MD. 21204



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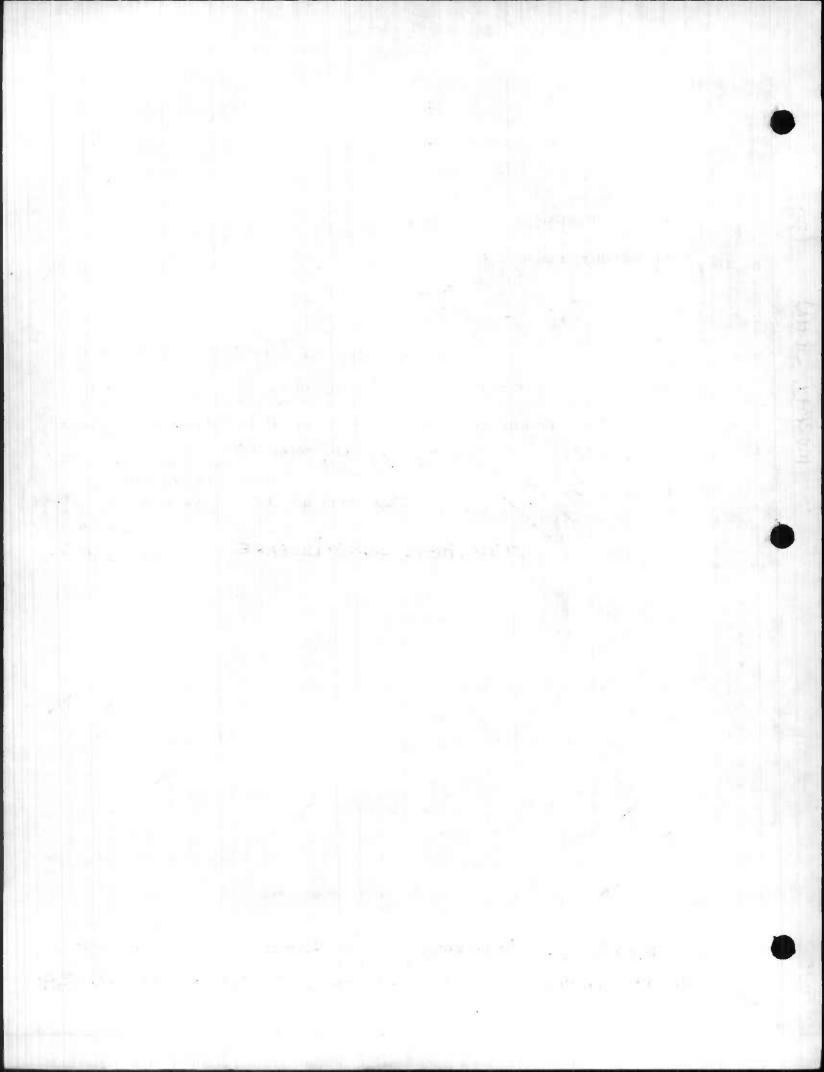
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month Day Year **Physician** MURPHY ,2000 4:30 PM MHOL JOSEPH FEB 6 /Medical 4c. County of Death 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** CENTER DAK CREST VILLAGE CARE PARKVILLE BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number **Funeral** 12M 20 F Months Deys 217-14-9568 Director MARCH 26, 1923 MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director BALTIMORE PARKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Norra 23s 3507 U.S.A # Funeral BLVD 8800 WALTHER 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WWIII 14. Rece - American Indian, 11. Merital Stefus Black, White, etc. an "natural", or iter Medical Examiner 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0020 p 3 ☐ Widowed 4 Ø Divorced Yeer or Detes: YVAN WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) C.S.X. 12 MANAGER OF LABOR RELATIONS RAIL ROAD 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental OL MURPHY LEO LA FONTAINE EVA 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) . mportant: If Item 27 46891 EATON TER. # 100 STEPLING, VA. 20164
ce of Disposition (Neme of Dete 20c. Location - City or Town, Stete ERIN MURPHY , DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other placa)

EVANS FUNDEAL CHAPEL

BEL AIR - P. A. 20a. Method of Disposition 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State FEB . 4 ☐ Donetion 5 ☐ Other (Specify) 2000 FOREST HILL MD. 22. Name and Address of Facility EVANS FUNERAL CHAPEL 21, Signeture of Funerel Service Licensee thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, PARKVILLE, MD 21234 23a Part1. Enter the disease of shock, or heart failure. List Approximate Intervel Between Onset and Deeth **Physician** ENDSTAGE LUNG DISEASE /Medical Immediate Cause (Finel disease or condition resulting in death) **Examiner** Dua to (or as a consequence of) Examiner sician and burial-transit that the death certificate be assecuted Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or es a consequance of): physician s the buriel Box 68760, Physician/Medical Due to (or es a consequence of) signed by the at 1 be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yss 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Wes an autopsy performed? The law 2 No certificate 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case refarred to medical examiner? Be 26. Pleca of Death (Check only ona) No No Hospitel: Other: Nursing Home 5 Rasidence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27 Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division Natural 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be detarmined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, sfreef, fectory, office building, etc. (Specify) in by 4 Homicide 24 hours a 1/ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) and manner as stated
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, and due to the causa(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number 2000 Name and address of person who completed cause of death (Item 23a) (Type, Print) walthe aulknems Sceltmane 31. Date filed (Month, Day, Year) Registrer's Signeture State EB 2 2 2000 Registrar

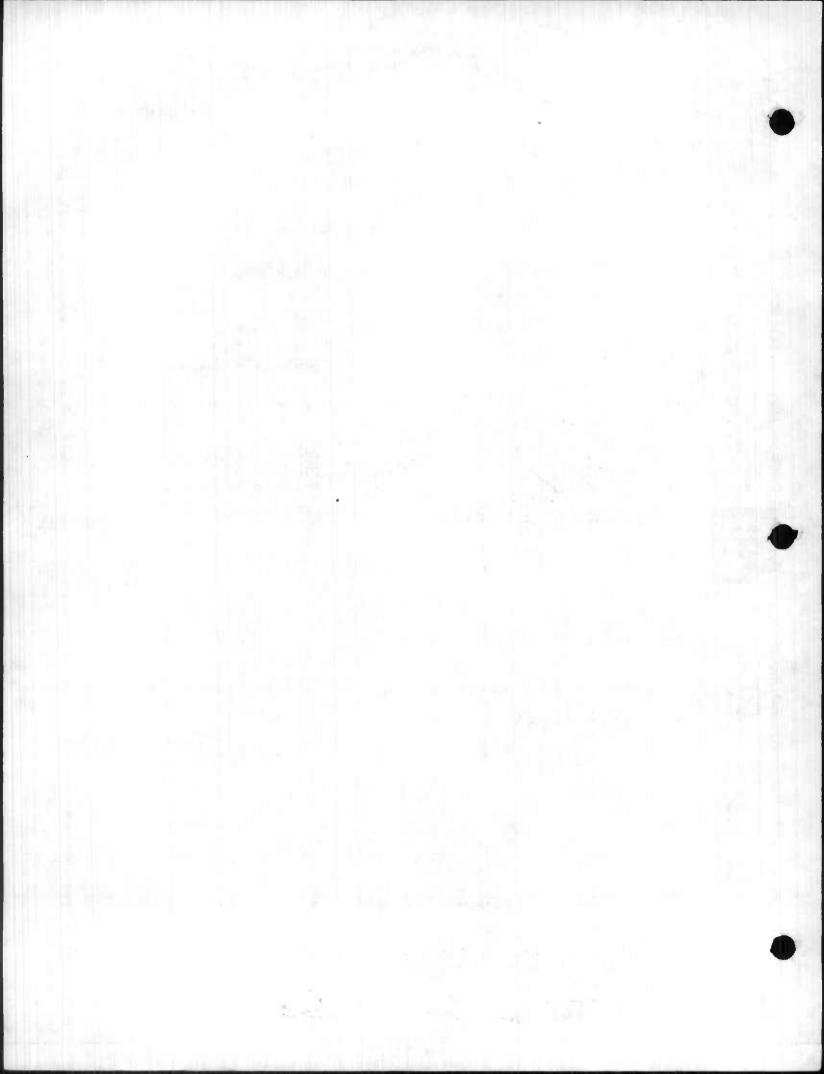
DHMH 16 Rev 6/95

MURPHY,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 1 7

| | | Certificate of Death | Reg. No. | 1 4400 | |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------|--|
| Physician | Decedent's Neme (First, Middle, Last) | | 2. Dete of Death Month Dev | 3. Time of Death | |
| /Medical | ADA LEE MASON | | | 2000 1515 | |
| Examiner | 4e Facility Name (If not institution, give street and number) | 4b. City, Town, or Lo | | | |
| | Sinai Hospital of Baltimor | | | I/A | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last | birthdey) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. | | Birthplace (State or Foreign Country) | |
| or itsms 23a or 23a-f show miner must be notified at Funeral Director | 215-32-7903 63 Usuel Residence of Decedent | 113. | MAY 26 1936 | MARYLAND | |
| | | own or Location | | 10d. Inside City Limits | |
| | MARYLAND N/A B | ALTIMORE CITY | | XIX Yes 2 No | |
| | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Wi | hat Country? | |
| | 2702 KEYWORTH AVENUE APT 110 | 21215 | U.S.A. | | |
| | 11 Merital Status 12. Was Decedent Ever in U.S. | 13. Wes Decedent of Hispanic Origin? (Spe If Yes, specify Cuben, Mexican, Puerto | | - American Indien, | |
| 2 | Armed Forces? 1 Never Married 2 Merried 1 Yes 222No | | - the second | , White, etc. | |
| þ | 3 XXidowed 4 □ Divorced If Yes, Give Yeer or Detes: | 1 Ves 2 1 No Specify: | Specify: | BLACK | |
| Completed | 15. Decedent's Education | 6a. Decedent's Usual Occupation | 16b. Kind of Bus | iness/Industry | |
| ed. | (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) | (Give kind of work done during most of working title. DO NOT use retired) | | | |
| , PO | 6th grade | HOUSEWIFE | FAMII | J.Y | |
| Be | 17. Father's Neme (First, Middle, Last) | 18. Mothar's Name | (First, Middle, Maiden Sumame |) | |
| 0 | CLARK D HIGGINS | BEULAH | CHOATES | | |
| | 19e. Informant's Neme/Ratetionship (Type, Print) | 9b. Mailing Addrass (Street and Number or Rura | I Route Number, City or Town, S | State, Zip Code) | |
| | Helen L. Higgins/Daughter | 2570 Druid Park Drive, | Baltimore, Mar | yland 21217 | |
| | 20e. Method of Disposition 20b. Plece | of Disposition (Name of etery, cremetory or other ptace) | Data 20c. Location - C | City or Town, State | |
| | TEX Burier 2 Li Cremetion 3 Li Remover from State | | -21-00 FOREST H | HILL MARYLAND | |
| # | 21. Signeture of Fundral Shorice Licenses | 22. Neme end Address of Facility | | | |
| 8 | 1 / Magringer | WILLIAM C BROWN COM | | HOME PA | |
| | 23a. Part En withe disease, or complications that caused the deeth. D | 1206 W NORTH AVENUE | | Approximate | |
| an | 23a. P. 1. E. L. fie disease, or complications that caused the deeth. D shield, or heart failura. List only one cause on each line. | | | Intervei Between Onset and Death | |
| 1 | Immediate Causa (Final | 1 -1 -1 | | 1 | |
| r | disease or condition resulting in death) a. Lactic | MC104315 | | | |
| ē | Due to (or as | e consequence of): | | | |
| Examiner | b | | | | |
| EXa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | e consequence of): | | | |
| | cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): | | | | |
| Medical | resulting In death) Last | e consequence ory: | | | |
| 2 | d | | | | |
| Cla | Pert II. Other algnificant conditions contributing to death but not resulting | o in the underlying cause given in Part I | 23h Did tohacco use cont | tribute to the cause of death | |
| hys | - 0 (| | | 3 Probably 4 € Unknow | |
| Y P | End stige renal disease | 2 | 10100 2010 | o Briosadi, in Committee | |
| Completed by Physician/ | d | | 24e. Was an autopsy | 24b. Were sutopsy findings | |
| jete | | | performed? | available prior to completion of cause of death? | |
| E P | | | 400 | | |
| ပိ | OF Wassessels and the residual | | 1 ☐ Yes 2/5€No | 1 Yes 2 No | |
| o Be | 25. Was case referred to medical axeminer? Hospitel: | 26. Place of Death | | | |
| - | 1/2 Inpatient 2 ER/ | Outpatient 3LI DOA 4LI Nursing Hor | me 5 Residence 6 Other 28d. Describe how Injury occurre | 1 | |
| Certification: | 1 Natural 5 Pending (Month, Dey Year) | | | | |
| Cat | 2 Accident investigation 3 Suicide 6 Could not be | M 1 Yes 2 No | 201 Leastion (Street and Number | e or Gural Bouta Number | |
| ŧ | 4 Homicide detarmined 28e. Place of Injury - At home, building, etc. (Specify) | , term, street, factory, office | 28f. Location (Street and Numbe City or Town, Stele) | or Abrai Aobie Number, | |
| | 200 Contillor of Contillor Division Table 1 | | 44 4 4 4 4 4 4 4 4 | | |
| edical | 29a. Certifiar (Check only one) Certifying Physician: To the best of my knowled (Check only one) and menner stated | ige, deeth occurred at the time, date and place, and/or investigation, in my opinion, daeth occurre | and due to the cause(s) and man and at the time, date and place, ar | nd due to the cause(s) | |
| ₩ | and menner stated. 29b. Signetyre and titte of certifier | 29c. License number | 29d Data signed | (Month, Day, Year) | |
| | X | A CC | | | |
| | David Dunar M. | 1115-000 | rebruary | , 16, 2000 | |
| | 30. Name and address of person who completed cause of deeth (Item 23s | a) (Type, Print) | / | | |
| | 2901 West Belveder Be | a (timore, MD) | | | |
| tate | 31. Date filed (Month, Day Year) 32. Registrer's Signeture | New A family. | | | |
| istrar | FEB 2 2 2000 Denne | p sporter | | | |



State Registrar

FEB 2 2 2000 DHMH 16 Rev 6/95

War.d

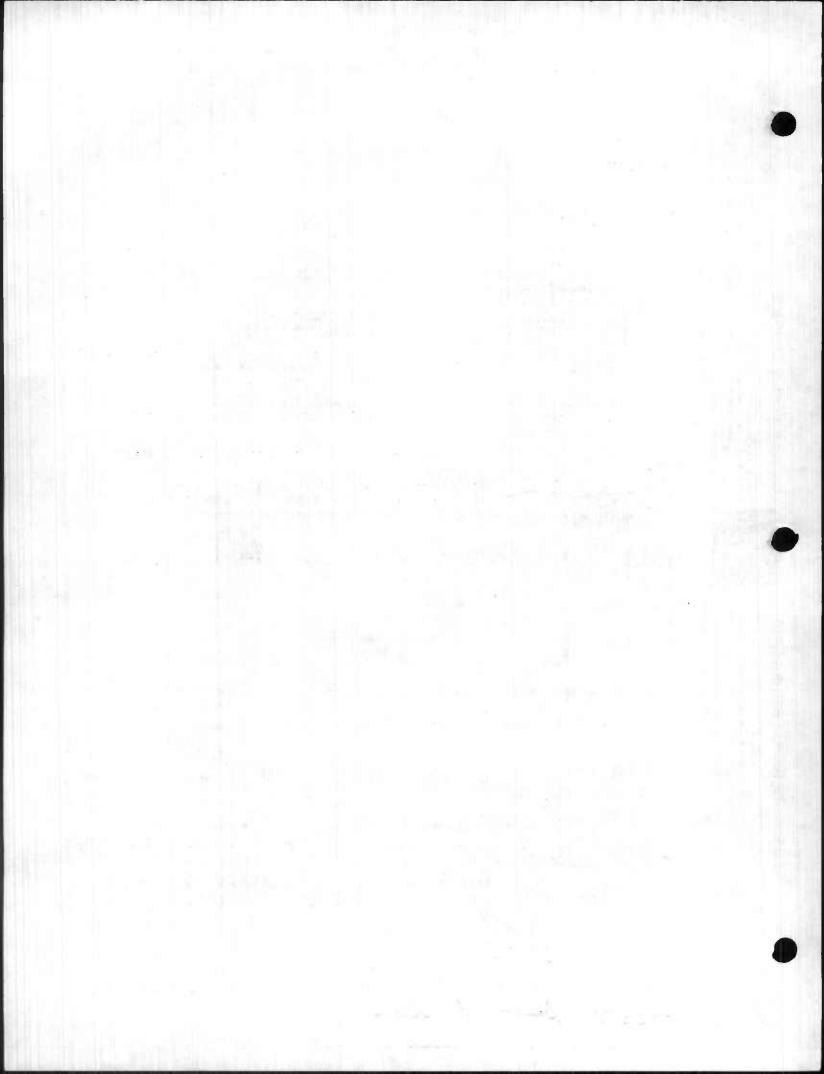
31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

row les

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene U Certificate of Death

Physician /Medicai Examiner

Funeral Director

28a-f show Items 23a death "natural", or The Medical nd Mental Hygiene. merked other than

Baltimore, Maryland 21215-0020 if Item 27 is marked of permit. Pages 1
Department of H
Important: if iten
any injury or ott

Physician /Medical Examiner

Box 68760.

P.O.

Records,

of Vital

Division

tran the 0 signed by t page 2 should this After

The law requires that the death certificate be executed or Attending Physician: To the Hospital or Attendin within 24 hours after death.

To the Funeral Diractor: Aft completely filled in by the fu

If Under 1 Year 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Months 1 M 200 F 219-44-6421 Usuel Residence of Decedent 10e State 10b County 10c. City, Town or Location Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 21211 3976 Edgehill Avenue Apt. D-10 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married ☐ Yes 2 💢 焼 o f Yes, Give Year or Dates: 1□ Yes 2√No by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Assistant 11 17. Father's Neme (First, Middle, Last) William Raymond McCauley 19a. Informent's Name/Reletionship (Type, Print) Ethlyn Tarr Sister 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition XBurial 2 Cremation 3 Remove from State Moreland Memorial Park 2/21/00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses art 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heap refure. List only one college on each line. Marosclartic Carbonascula Deser Immediate Ceuse (Final disease or condition resulting in deeth) Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or trijury that initiated events resulting in deeth) Lest e to (or es a consequence of) Due to (or as a consequence of). Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. þ Completed Be 25. Wes case referred to medical 26. Place of Death (Check only one) eraminer?
10 Yes 2 1 Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 70 2□ No Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 critifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the ceuse(s) end manner as stated.

2 Medicat Examiner: On the basts of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) end manner stated. Medical (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

B. A. COCH VAN, M. D., 846 W 36 STREET, Bulk M. d. 2/2// 31. Date filed (Month, Day, Yeer)

1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3 Time of Death Month Dorothy McCauley February 18, 2000 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Home, 3976 Edgehill Avenue N/A Apt. D-10 Baltimore 9. Birthpiece (State or Foreign July 22,1917 | Baltimore, MD 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? USA 14. Rece - American Indien, Bleck, White, etc. Specify white 16b. Kind of Business/Industry Keswick Multi-Care 18. Mother's Name (First, Middle, Meiden Sumeme) Mary Virginia James 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4300 Newport Avenue BAltimore, Maryland 21211 20c. Location - City or Town, State Parkville, MArvland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Betw Onset end Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury et 28d. Describe how injury occurred Location (Street and Number or Rurel Route Number, City or Town, Stete)

32. Registrar's Signature

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5450 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** FEBRUARY 4c. County of Death JAMES MILLER 2:02 Pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give stre at and number Examiner Jac DOG antel altimore If Under 24 Hrs. B. Date of Birth Hours Min. (Month, Day, Year) Aug 26, 1924 Birthplace (State or Foreign Country) MD 5. Social Security Number 6.8 7. Age (In yrs. last birthday) If Under 1 Year Days Months 10 M 20 F 75 213-20-5566 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Director Linthicum **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 526 Greenwood Road Funeral 21090 USA. 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armed Porces: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 42-45 1 Never Married 2 Married 1 Yes 2 No Specify: white Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 16. Mother's Nama (First, Middle, Maiden Surname) 17 Father's Neme /First Middle Last) 8 Albert James Miller Evelyn B. Neal 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Harbor Hospital 3001 S. Hanover Street baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☑ Donation 5 ☐ Other (Specify) State Androng Board 655 W. Baltmore Street 21. Signature of Funeral Service Licensee Joseph B. Van Sant 13.0 21201 Baltimore, MD 200 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final Muscardia Acute < I hour disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ohknown p 24b. Were autopsy lindings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yas 2 No Be 25. Was case refarred to medical 26. Place of Death (Check only one) axaminer? Hospital: 20 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Inpatient 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

that the death certificate be executed physician and s the buriel-transit Box 68760, 80 signed by the e P.O. Records, should I P88 Division of Vital 8 Affiar Attending after death. Director: A To the Hospital or Within 24 hours after To the Funeral Dir 6

Funeral

Director

7 is marked other than "natural", or hama 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

pemit. Pages 1 and 2 abould be filled within 72 hours effer of Department of Health and Mentel Hygiene. Important: if Nem 27 is marked other than "netural", or her any injury or other traumatic event, the Health Exercises

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

the Menyland

death

29b. Signat

29a. Certifie

cover)

31. Data filed (Month, Day, Year)

Same

State

Registrar **DHMH 16 Rev 6/95**

54630 Horbor Hosp

32. Registrar's Signature

Buch

40025054

29c. License number

c. On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

Continuing Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

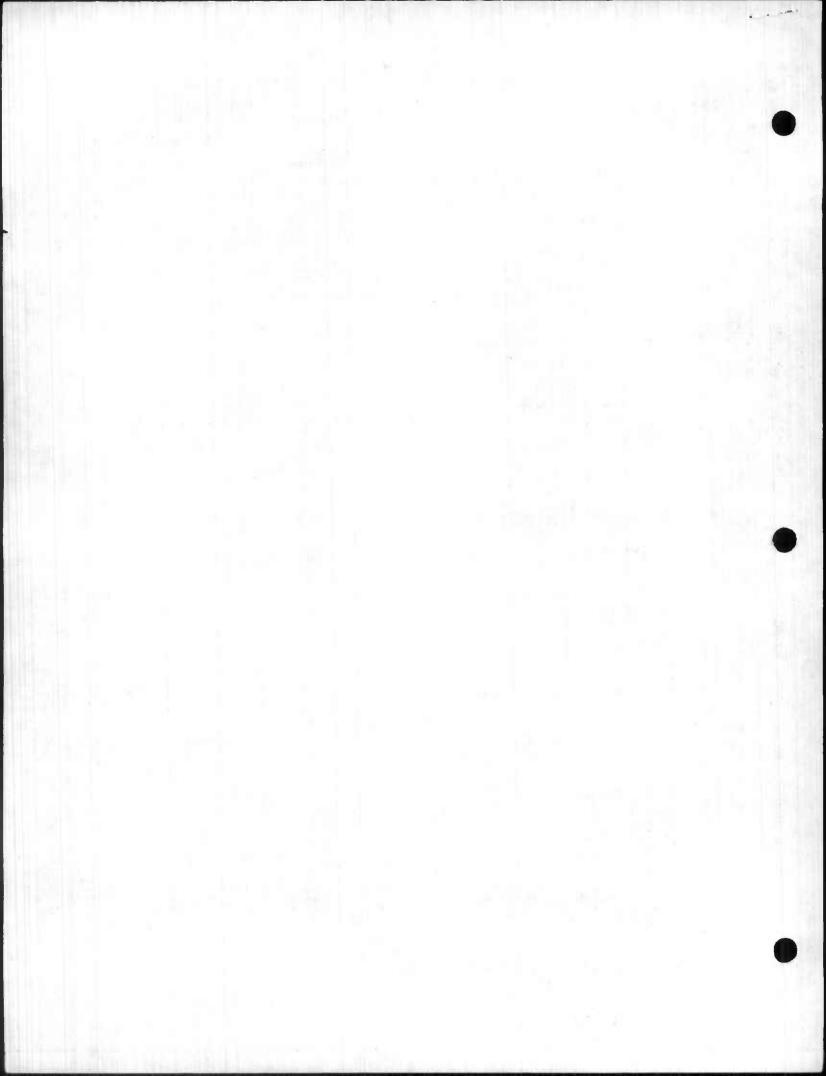
29d. Date signed (Month, Day, Year) 11/00

Baltimore MD 21225

Welker Hosp, talist ss of pe soft who completed cause of death (Item 23a) (Type, Print) A. Welker

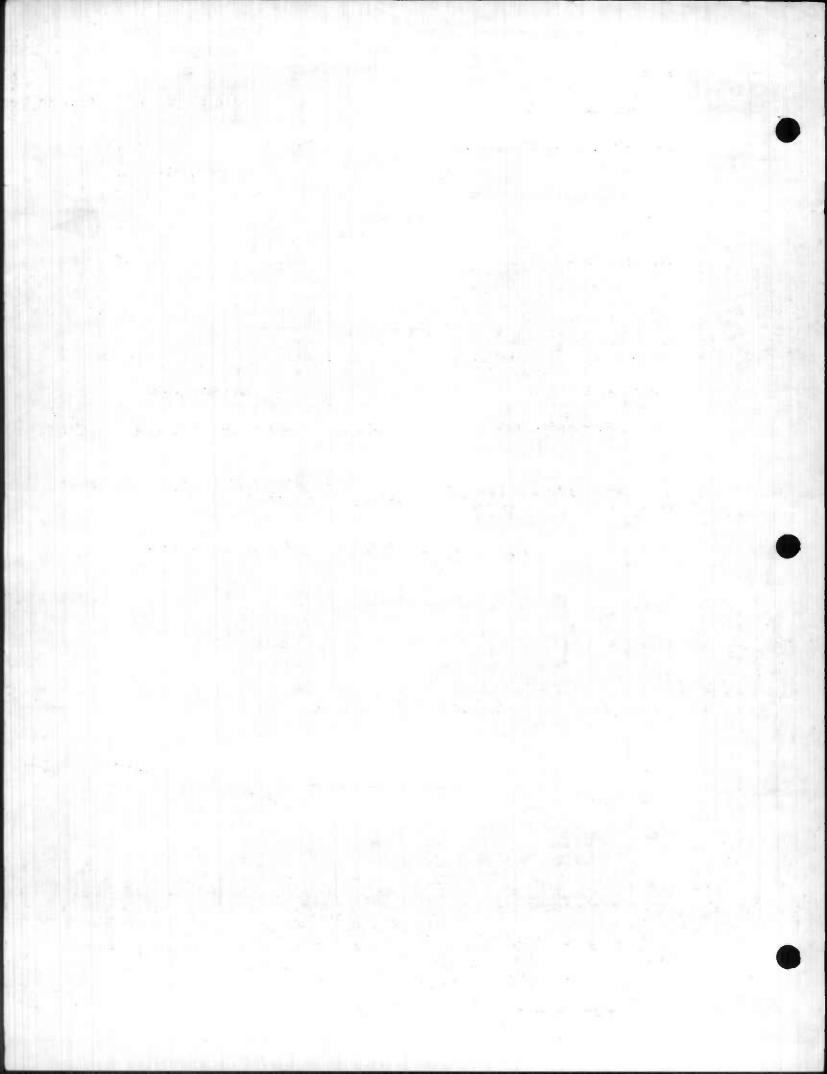
FEB 2 2 2000

3001 S. Hanover St.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

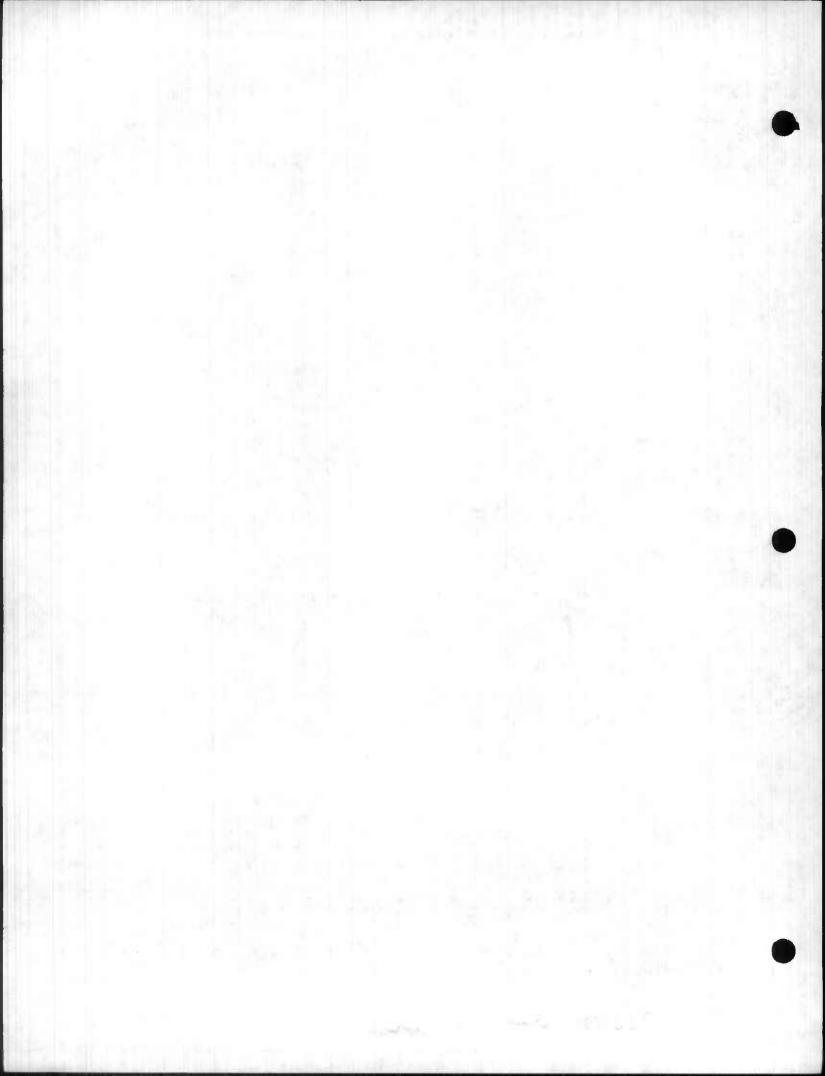
| ITEM #19a | State of Maryland / Department of Health and M PER FH G780 2/24/2000 AH Certificate of Death | | ene | 15451 | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--|--|--|--|--|
| Physician */Medical | Decedent's Name (First, Middle, Last) FRANCES MOOREHEAD | 2. Dete of Deeth Month JANUARY | Pay , 2000 | 3. Tima of Death 9:57 AM | | | | | |
| Examiner Funeral Director | 4a Facility Neme (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL 5. Social Security Number 220-01-0247 1□ M 2\(\text{M} \) F OE Yrs. 4b. City, Town, or Lo Baltimor If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | | 4c. County of Death N/A 9. Birthp Court 1914 MD | blace (State or Foreign | | | | | |
| | Usual Residence of Decedent | march 3, | 1914 MD | | | | | | |
| 23a or 28a-f show ust be notified at | 10a. State 10b. County 10c. City, Town or Location | | 1 | 0d. Inside City Limits | | | | | |
| ill of | MD N/A Baltimore | | | Yes 2□No | | | | | |
| Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Co | | | | | | | | |
| | | | USA | | | | | | |
| by Funeral | | Rican, etc.) | 14. Race - Americ Bleck, White, Specify: | etc. | | | | | |
| tad | 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of worki | 1 | 6b. Kind ot Business/Inc | White | | | | | |
| Completed | (Specify only highest grade completed) (Give kind of work done during most of works life. DO NOT use retired) | "" | | | | | | | |
| S | unknown unknown unknown | 16: 16: 11 | unknow | n. | | | | | |
| B | 17. Father's Name (First, Middle, Last) 18. Mother's Name | | | | | | | | |
| F | Henry W. Lohmeyer 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Pura | harlotte | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | Code | | | | | |
| | Winston Morehead/spouse 20e. Method of Disposition 1 | | altimore N | | | | | | |
| Department of neath and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinet must be notified at once. To Be Completed by Funeral Director | 21. Signature of Funeral Service Licenses Joseph B. Van Sant 22. Name end Address of Fecility State Anatomy Board Baltimore, MD 21201 | 655 W. | Baltimore S | Street | | | | | |
| icai ner lexal lexallex | Immediate Cause (Final disease or condition resulting in deeth) e. Euch Clumic Clost Clumic Clost Clumic Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Clost Cl | Trul | De seas | 9 | | | | | |
| Physician/Medical Examine | Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): | | | | | | | | |
| / Physician/Mec | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tol | bacco use contribute to | o the cause of death? | | | | | |
| by Phy | I selwic Heat Plineare | 1 ☐ Ye | 1 Yes 2 No 3 Probably 4 Henking | | | | | | |
| Completed | | 24a. Was an perform | ed? av | ere autopsy tindings allable prior to impletion of cause death? | | | | | |
| Con | | 1 □ Ye | s 2 1 No 1 | Yes 2/2/No | | | | | |
| 9 | 25. Wes case referred to medical examiner? | Check only one |) | | | | | | |
| leath. tor: After this c tha funaral dire cation: To | 27. Menner of Deeth 1 Naturel 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No | 28d. Describe ho | reet and Number or Rura | | | | | | |
| | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, to | and due to the ca | use(s) and manner as s | | | | | | |
| edicai | one) and menner steted. | | | | | | | | |
| Σ | 29b. Signature and title of certitier 29c. License number | | d. Date signed (Month, | | | | | | |
| |)900100 c1 M. D08358 | + | -OB 8 2 | 000 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8903 HA; GRAGO F. PITTOGO BACT. IN | PARISE | PO 4 0 SAD 2/2 | 34 | | | | | |
| State Registrar | 31. Date tiled (Month, Day, Year) Segletter's Signature 32. Registrar's Signature | | | | | | | | |



| 1. Decedent'a N | lama (First, Middle | , Last) | | | rtificate of | | 2. Deta of De | | | of Death |
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| Alfons | Alfonso S. Matthews | | | | | Februa | ry 18, | 2000 3° 2 | 300 | |
| 4a Facility Nam | a (ff not Institution | , give street and n | umber) | | | 4b. City, Town, or L | | | | Pin |
| | Arundel I | | | | | Glen Burr | | | Arundel | |
| 5. Sociel Securit | | 6. Sex 1 → M 2 □ F | 7. Age (In) | yrs. last birthdey) Yrs. | Montha Deya | | (Month, De | y, Year) | Birthplace (State Country) | or Foreign |
| 214-30- Usuel Residence | | 7.21 | 70 | | | | Aug. 1 | 1, 1929 | Md. | |
| 10a. Stete | 10b. County | | 10c. | . City, Town or Lo | ocation | | | | 10d. Inside | |
| Md. | Anne A | rundel | | Severn | 1 | | | | 1 🗆 Y | s 377No |
| 509 Que | Number eenstown | Road | | | 10f. Zip Code 211 | 44 | | USA | What Country? | |
| 11. Marital Stetu | | Armed F | | n U,S. 13. \ | Wes Decedent of It Yas, specify Cul | Hispanic Origin? (S) ben, Mexican, Puert | pecify Yas or No o Rican, etc.) |)- 14. Rad Bla | ce - Amarican Indian, ck, White, etc. | |
| | farriad 2. Marri ad 4. □ Divorced | ed to Yaa If Yes, C Yeer or | i 2 ☐ No Give Detes: | 100 | 1□ Yas 2√0 No | Specify: | | Specif | Black | |
| | 15. Decedent | 's Education | | 16a. Deced | dent's Usuel Occu | upation | | 16b. Kind of B | usiness/Industry | |
| | pecify only highes econdery (0-12) | | (1-4or 5+) | (Give | kind of work done DO NOT use retire | e during most of worked) | | Westing | | |
| 10th G | rade | | | Packe | r | 1 00 10 10 10 10 | | Electri | | |
| | ne (First, Middle, I lo Matthe | | | | | 18. Mother's Nem Cornelia | | | ne) | |
| 19e. Informent's | s Neme/Reletionsh | nip (Type, Print) | | 19b. Mailir | ng Address (Stree | et and Number or Ru | rel Route Numb | er, City or Town | , Stete, Zip Code) | |
| Phyllia | s Q. Matt | thews | wife | 509 Q | ueenstow | n Road Se | evern, M | id. 2114 | 4 | |
| 20e. Method of | Disposition 2 Cremetion | 2 Demoved from | | b. Piece of Dispo cematery, crer | osition (Neme of metory or other pla | ece) | Dete | 20c. Location | - City or Town, Stete | |
| | on 5 Other (Sp | | Sa | | st Cemet | | 'eb. 23 | Harmon | | |
| 21. Signeture o | f Funerel Service L | icensee | | | | ress of Facility Nu | | | | |
| ble | west " | E. nutt | er | 25 | 01 Gwynn | s Falls F | KWY Bal | timore, | Md. 2121 | |
| | heert teilure. List | complications that only one cause on | t causad tha d | daath. Do not ent | ter the mode of dy | ring, such as cardiac | | rrest, | Approxin Intervel E Onsat ar | ete etween |
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Location City or To | tobacco use co | Intervet E Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat are Onsat | ete etween d Death d Death s consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer consumer c |

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ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** February 11, 2000 1:57p.m. /Medical George Morton 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** North Arundel Hospital Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) 80 vrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20, 1919 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 233-18-1964 11X1XI 2□ F Alabama Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Md. Glen Burnie 1 Yes WNo Director farms 23a or 28a-f the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 42 Brooks Terrace Road IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. Department of Health and Aerial Hygiene. Important II lean 21 is merited other than "nature! any injury or other transmission. 1 Never Merried 2 Married 1 ☐ Yes 2 → No If Yes, Give Yeer or Detes: **Black** 1 Yes 2 No Specify: 21215-0020 à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Supervisor Kane Transfer Co. Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Morton Corrine Bell 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Beatrice Morton wife 42 Brooks Terrace Road Glen Burnie 21060 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 DExiriel 2 Cremetion 3 Removel from State Feb. 15 Baltimore, Md. Arbutus Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Service Licensea 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Kitter 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical UNOSBOSI)
Due to (or es e consequence of): Examiner Examiner BHYDAMTZUA The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) and the burial-trar Box 68760, CBRILBHUMSCUM ACCIDINAT Physician/Medical Due to (or es a consequence of) USB as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. detached 1 Yes 2 No 3 Probably 4 Unknown signed by t þ Records, Be Completed 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? peed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Attanding Physician: funeral director. 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer? Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 CR/Outpatient 3 DOA edical Certification: To this 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred After Division 1 Neturel 2 Accident 5 Pending 1 Yes 2 No To the Hospital or Attandition within 24 hours after death.

To the Funeral Director: A investigetion 3 Suicide 6 ☐ Could not be determined Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

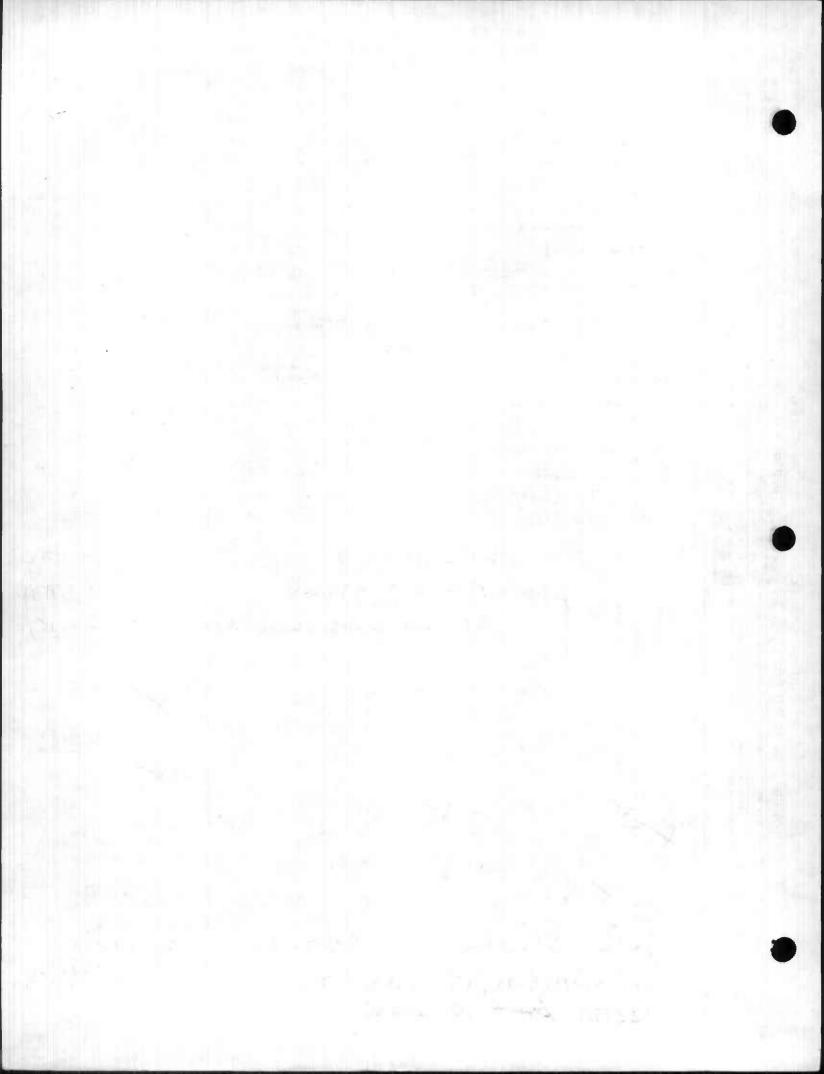
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end #5 of certifier 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAVENS CAMP MAROR RA 518

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Dey, Year) FEB 2 2 2000

32. Registrer's Signeture

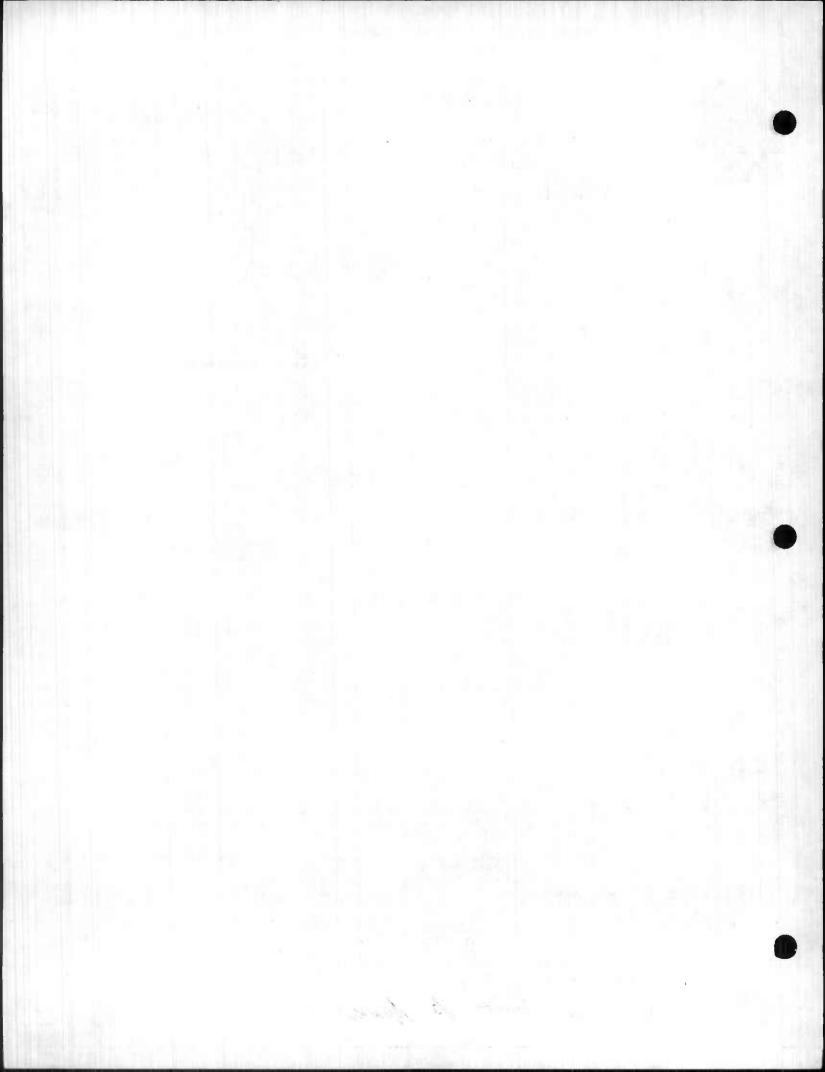


State of Maryland / Department of Health and Mental Hygiene

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| Physician | 1. Decedent's Name (First, Middle, Les | E. MV | ANLE | 4, | | 2. Data of Dea Month | th Day | Year | 3. Time of Death |
| /Medical Examiner | 4a Facility Name (If not institution, give | street and number) | | | 4b. City, Town, or L | | 4c. County | 000 of Death | 0,00 |
| | Annapolis Nursin | | | | Annapoli | | Anne | | |
| Funeral Director | | ex 7. Age (In yi | rs. last birthday) Yrs. | Months Days | Hours Min. | 8. Dete of Birth (Month, Day Nov. 8, | Year) 1904 | Count | ace (State or Foreign lry) Chusetts |
| 2 3 | Usual Residence of Decedent 10e. State 10b. County | 10c. | City, Town or Lo | ocation | | | | 10 | Od. Inside City Limits |
| Aarylar Tahow | | | | | | | | | ▼⊠ Yas 2□ No |
| vith the Maryle or 28a-f abor be notified at Director | MD Anne Aru | nder | Annapo: | 10f. Zip Code | | T, | 0g. Citizen of W | That Count | hn/2 |
| # 0 4 0 | 900 Van Buren S | treet | | 21 | 401 | | USA | | |
| urs efter | | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: | | Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No | Hispanic Origin? (Sp pan, Mexican, Puerto Specify: | pecify Yas or No- p Rican, etc.) | | - America k, White, a Whi | ntc. |
| natural, | 15. Decedent'a Ed (Specify only highest gra | | | dent's Usual Occu | pation during most of work | kina | 16b. Kind of Bu | siness/Ind | ustry |
| S 1.3 | Elementary/Secondary (0-12) | College (1-4or 5+) | lile. | DO NOT use retire | ed) | | Medicia | ne | |
| tal Hyg d other avent, | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nem | e (First, Middle, | Maiden Sumam | e) | |
| Menta Menta mrked afte ev | | rts | | | Catheri | ine McIn | nis | | |
| EDEE | 19a. Informant's Name/Relationship (1 Barbara Steinber | | | The Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Co | t and Number or Ru | | | | |
| Pages 1 and 2 is ant of Heelth ar nt: If Item 27 le ry or other trau | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify | Removel from State | Plece of Dispo cemetery, cre etro Cre | osition (Nema of matory or other pla ematory | ace) | 02/22/ | 20c. Location - City or Town, Stete | | |
| pemit. Pages 1 at Department of Hee Important: If Nem; any Injury or other once. | 21. Signature of Funeral Service Licen | | 23 | 2. Name and Addr. Hardest | ass of Facility Y Funeral | | | Le, h | |
| 402 6 0 |) Vicale (| J. Dulla | | 12 Ridg | ely Avenu | e, Annap | olis, M | D 214 | 101 |
| Physician /Medical Examiner | Immediate Cause (Finel disease or condition resulting in death) | a Due to | y as occopion | per | kurio | nta | -h | | 12h gea |
| ifficete be g physicia as the bur | Cause (Disease or injury that initialed events resulting in death) Last | c. | (or as a consec | 1000 SEC. 11242 | | | | | |
| at the death ce d by the attendietached for us. | Part II. Other significant conditions co | ontributing to death_but not r | esulting in the u | inderlying cause gi | iven in Part I. | 23b. Did to | obacco use con | tribute to | the cause of death? |
| . 45 00 > | Den | Dene Fr | | | | | 1 Yea 2 No 3 Probably | | |
| been shoul | Str | des | | | | 24a. Was a perfor | in autopsy med? | 24b. We ava con of c | ora autopsy findings illable prior to appletion of cause death? |
| The late he page | | | | | | 1 U Y | es 2 No | 10 | Yes 2□ No |
| slan: stor stor | 25. Was case referred to medical | | | | | th (Check only or | ne) | | |
| 2 00 2 | 1 Yes 2/ No | | ☐ ER/Outpatie | nt 3LI DOA | | ome 5 Resid | ence 6 Othe | er (Specify | 9 |
| To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: T | 27. Maneer of Death 1 Natural 5 Pending 2 Accident Investigation | (Month, Day Year) Injury Work? | | | 28d. Describe h | d. Describe how injury occurred if. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| or Attending after death. Olrector: After din by the fune din by the fune. | 3 Suicide 6 Could not be determined | 286. Place of injury - At nome, ferm, street, fectory, office | | | | | | | |
| To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification | 29a. Certifier Check only one) Certifying Phy | rsician: To the best of my k iner: On the basis of exami and manner stated. | nowledge, deat netion and/or in | h occurred at the to vestigation, in my | ime, date and place, opinion, deeth occur | , and due to the c rred et the time, c | ause(s) and ma late end piece, s | nner as st and due to | ated. the cause(s) |
| Me We | 29b. Signature and title of portifier | | 1 | 29c. Licen | se number | 1 | 29d. Data signed | (Month, I | Day, Year) |
| 841 | 2000 |) All . | A lus | 0 | 0/ | | | - | 100 |
| 7 | 30. Name and address of person who o | completed cause of death (It | em 23a) (Type, | Print) | TH DUE | TF /21) | ANNIA | Pus | 2000 2044-107 |
| State | 31. Date filed (Month, Day, Year) FEB 2 2 2000 | 32. Registrar's Sig | nature | 1 | 1000 | | 7 . 1071 | 1 | 707 |
| Registrar | FEB 2 2 2000 | Maria | D. A. | oaks | | | | | |

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05455 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Evelyn F. Montgomery 4b. City, Town, or Location of Death 16 2000 6:30 A.M. 4c. County of Death 4a Facility Neme (If not institution, give street and number) Potomac Valley Nursing Home Montgomery Rockville If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. Months Hours 1□ M 23F 209-38-1112 90 Mt.Pleasant, PA. Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location t0d. Inside City Limits 1 Yes 2 No MD. Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 Potomac Valley Road 20895 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ■Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) John Elder Maude Rist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9415 Seddon Rd. James Montgomery-Son Bethesda, MD. 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burlai 2 Cremation 3 Removat from State Scottdale Cemetery 02/18 Scottdale, PA. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 217 No t ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpetient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mender of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 1 Neturel 5 Pending investigation

Examiner ician and burial-transit The law requires that the death certificate be executed physician the burial Box 68760. 8 for use P.O. been signed by the should be detached Records, page 2 Division of Vital funeral director.

Physician

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filed within 72 hours after

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Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Completed by Physician/Medical 8 Certification: To

edicai

or Attending Physician: 24 hours after death. filled in by Hospital

completely within 2 g,

DHMH 16 Rsv 6/95

31. Date filed (Month, Day, Year) State Registrar

29b. Signeture and title of certifier

2 Accident

4 Homicide

(Check only one)

3 Suicide

29e. Certifier

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

1☐ Yes 2☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29d. Date signed (Month, Day, Year) 2000

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myron L. Lenkin, M.D.

11906 Darnestown Rd. Suite G, N. Potomac, Md. 20878

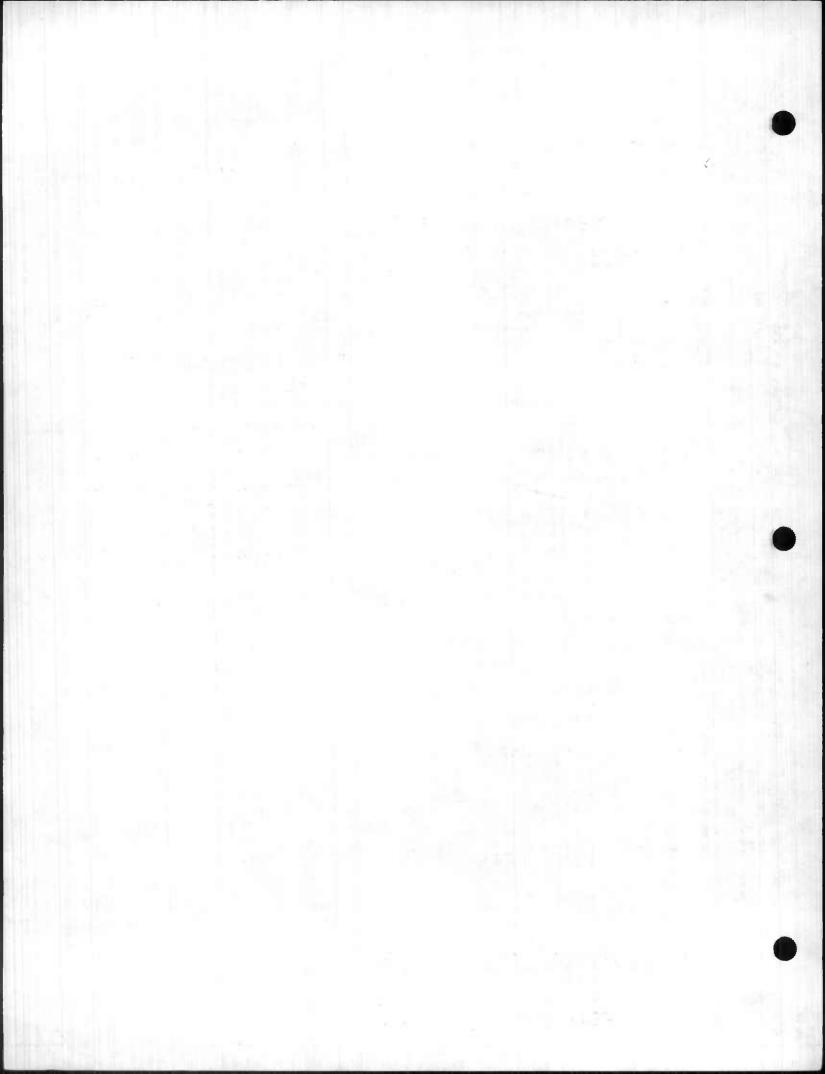
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FEB 2 2 2000

6 Coutd not be determined

32. Registray's Signature Lener

oaiks

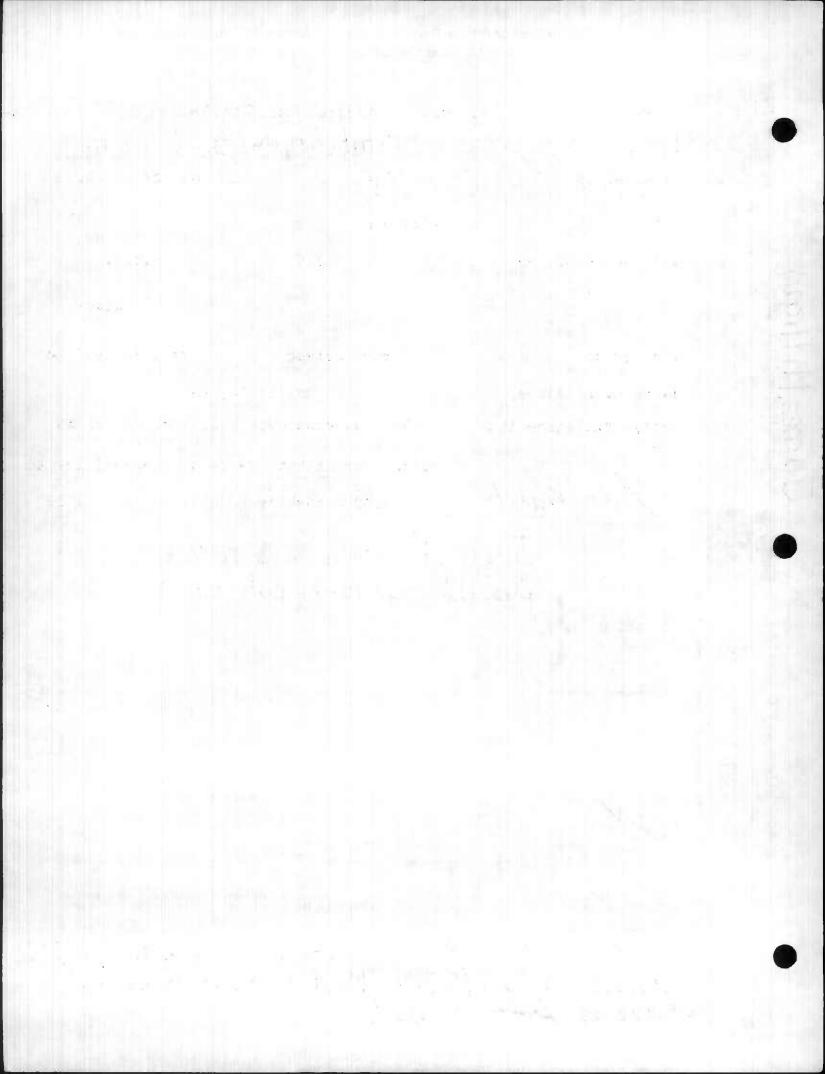


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 05456. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician** teloruani 14 Milligan Sr. W /Medical James Ac. County of Death 4b. City, Town, or Location of Death 4a, Facility Nama (If not Institution, give street and number) Examiner Baltimore City If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 10M 20 F Deys Hours Min Yrs. 72 **Director** 216-20-6205 Usual Residence of Dacedani 05 09 27 M.D 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits XXes 2□No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda D. than "natural", or items 23s or the Medical Examiner must be r U.S.A.

14. Race - American Indien,
Bleck, White, atc. Funeral 4504 Penhurst 21215 Ave 12. Wes Dacedant Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxicen, Puarto Rican, etc.) 11. Marital Status 1 XYas 2 No If Yes, Giva 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: If Yes, Giva Yeer or Detes: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Brill's Seafood Truck Driver 11th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be and 2 should be Montal Nellie Rogers James H. Milligan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) .00 / Health Nem 27 is 4504 Penhurst Ave, Baltimore Md 21215 Evelyn Milligan-Wife Saltimore, 20b. Placa of Disposition (Nama of cemetery, crematory or other placa) Data 20c. Location - City or Town, Stata 20a. Method of Disposition Pages 1 XBurlal 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 2-22-00 Owings Mills, Md Garrison Forest Vet 22. Nama and Address of Facility
March F/H West 21. Signature of Funaral Service Licenses 4300 Wabash Ave, Baltimore Md 21215 pliestions that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical **Examiner** Physiclan/Medical Examiner certificate be executed physician and sthe burial-trens Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) S (5) attending 039 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death2 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, by Completed 24a. Was en autopsy 24b. Wara autopsy findings available prior to complation of cause of death? The law i certificate hes t 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medice! 26. Placa of Death (Check only one) axaminar? Hospital: Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 30 1 Yes 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 1 PNatural 5 Pending invastigation death. 1 Yas 2 No 2 Accident Director: / 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1(Dertifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifier edicai 29b. Signatura and titla of certifier 29d. Data signed (Month, Dey, Year) 29c. License number M Dalsania MID is of person who completed ceuse of death (Item, 23a) (Type, Print) FEB 2 2 2000 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Joseph John Marchiano, Jr. 4:15 PM February 17,2000 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Dundalk Baltimore 842 Mildred Avenue If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Days Months Hours 1[XM 2□ F 216-36-7481 Sept. 18,1939 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 842 Mildred Avenue 21222 United States 14. Race - American Indian Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) NO Yes 2 No If Yes, Give 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2€ No Specify: 3 ☐ Widowed 4 ☑ Divorced Yeer or Detes: 1961-65 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electric Company Electrician 12 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) May Marie Salvo Joseph John Marchiano, Sr. 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1300-L Scottsdale Drive Bel Air, Maryland 21015 Frances M. Bonkowski/Sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete P☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 2/21/2000 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility Duda-Ruck Funeral Home of Dundalk, Incl. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERS DISEASE Lees Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Hypertension, REWAL Insufficiency 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to FOCAL glomenlo Sclewsis 24e. Wes an autopsy completion of cause of death? 1 ☐ Yes 2 🗷 No 26. Place of Death (Check only one) Hospitel: Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide

Examiner physician and the burial-transit Box 68760. P.O. à signed b Records, The law requires Division of Vital septal or Attanding Physician: hours after death. ineral Director: After this certifica

Physician/Medical p Be Completed Certification: To

To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medicai State Registrar

Physician

/Medical

Examiner

Director

Funeral

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"natural", or items 23s or

Hygiene.

Important: If New 27 is marked of any Injury or other Pages 1 and 2 should be nert of Health and Mental

Physician /Medical

Examiner

filed within 72 hours after

altimore, Maryland 21215-0020

25. Was case referred to medicel examiner? 1 Yes 2 No 27. Menner of Death 1 Netural 2 Accident

4 Homicide

29e. Certifier (Check only one)

6 Could not be

28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Jelets, us.

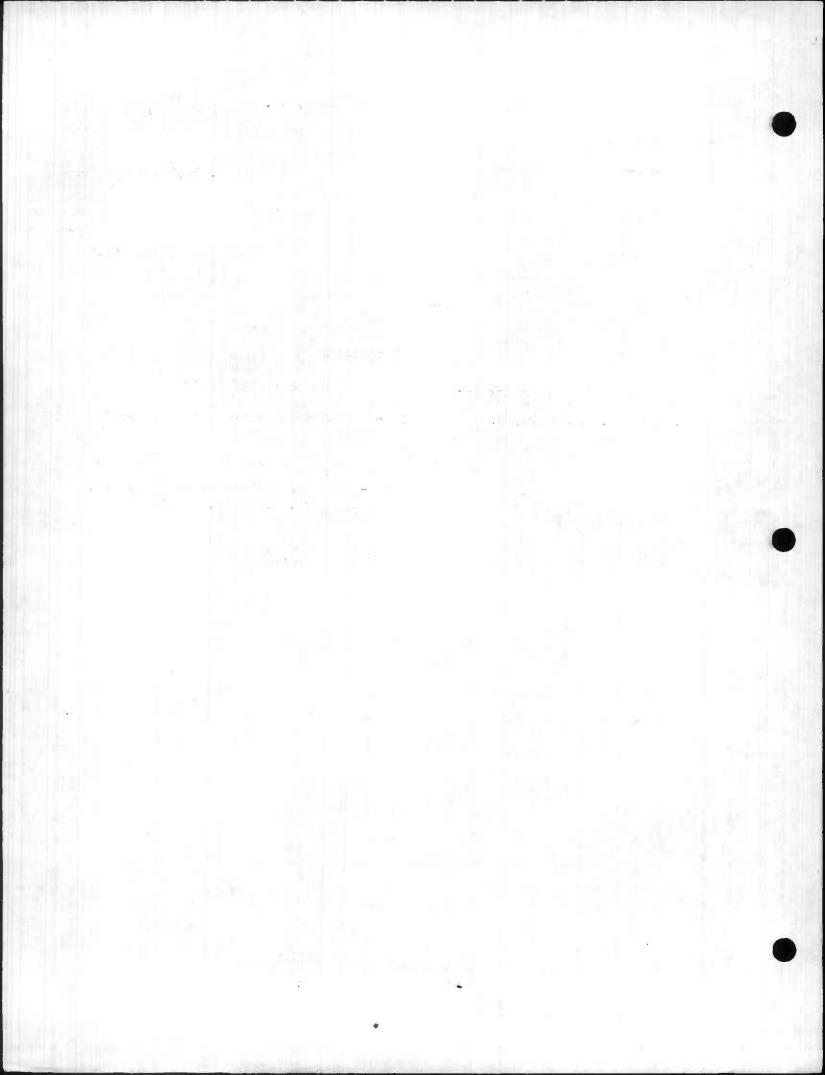
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

ROBERT LIBERTO MD 3508 BANK ST.

31. Date filed (Month, Dey, Year) FEB 2 2 2000 32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:50 PM Frank Voigt Miller February 15, 2000 ' /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Meridian Nursing Center at Franklin Woods Essex Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□F Hours Director 203-12-8358 March 31,1924 Pennsylvania Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23s or 28s-f show the Medical Examples must be nothed at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with United States 21222 19 Northship Road Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No It Yes, Give Year or Dates: 43 to 46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or ital 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 12 years Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mildred Voigt Frank C. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19 Northship Road Baltimore, Maryland 21222 Mrs. Ruth Miller Wife other 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Hilltop Service Corp. 2/17/2000 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 1,500 7922 Wise Avenue Baltimore, Maryland 21222 23a. Part 1 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Preumonia Zwks Examiner Due to (or as a consequence of): Examiner Disease > 5YRS rankinsons physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be execu Records, P.O. Box 68760. Physician/Medical the Due to (or as a consequence of) 88 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given In Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu has 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Phyafofan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) 29a. Certifier Medicai (Check only one) To the I within 2 and manner stated. 29c. License number 29d. Date aigned (Month, Day, Year) 29b. Signature and litle of certifier Bradford L. Elizaht MD 2/17/00 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Belain Rd Batt, MO 21236 goods

DHMH 16 Rev 6/95

State

Registrar

BRADFORD

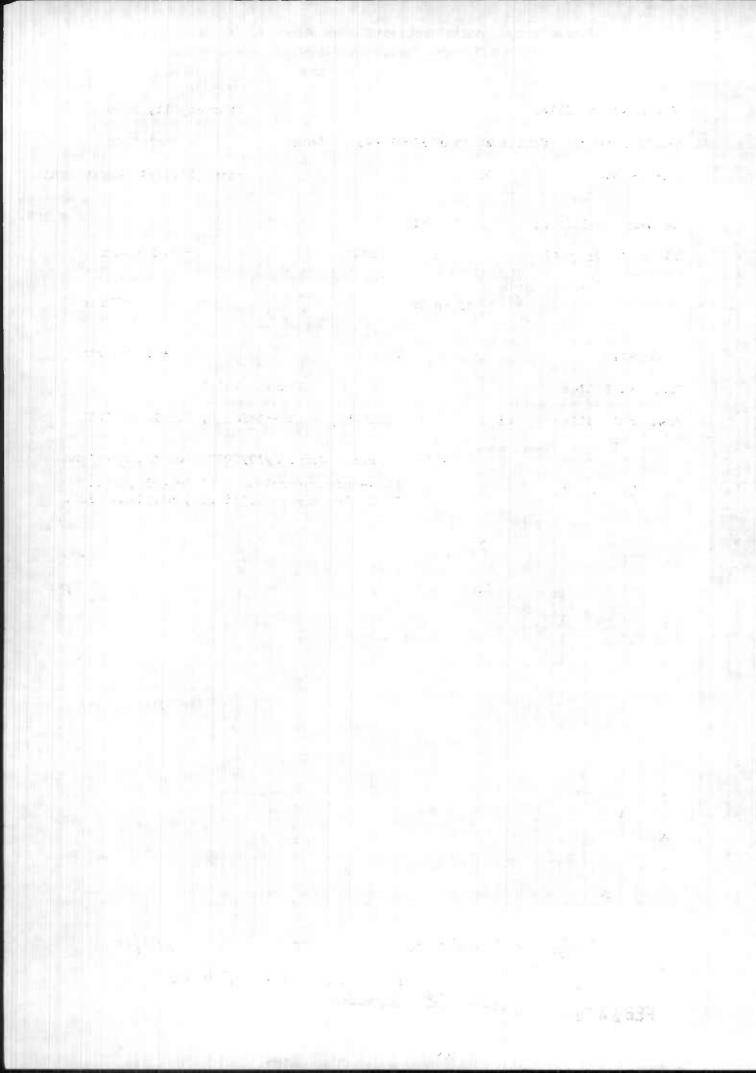
2000

31. Date filed (Month, Day, Year)

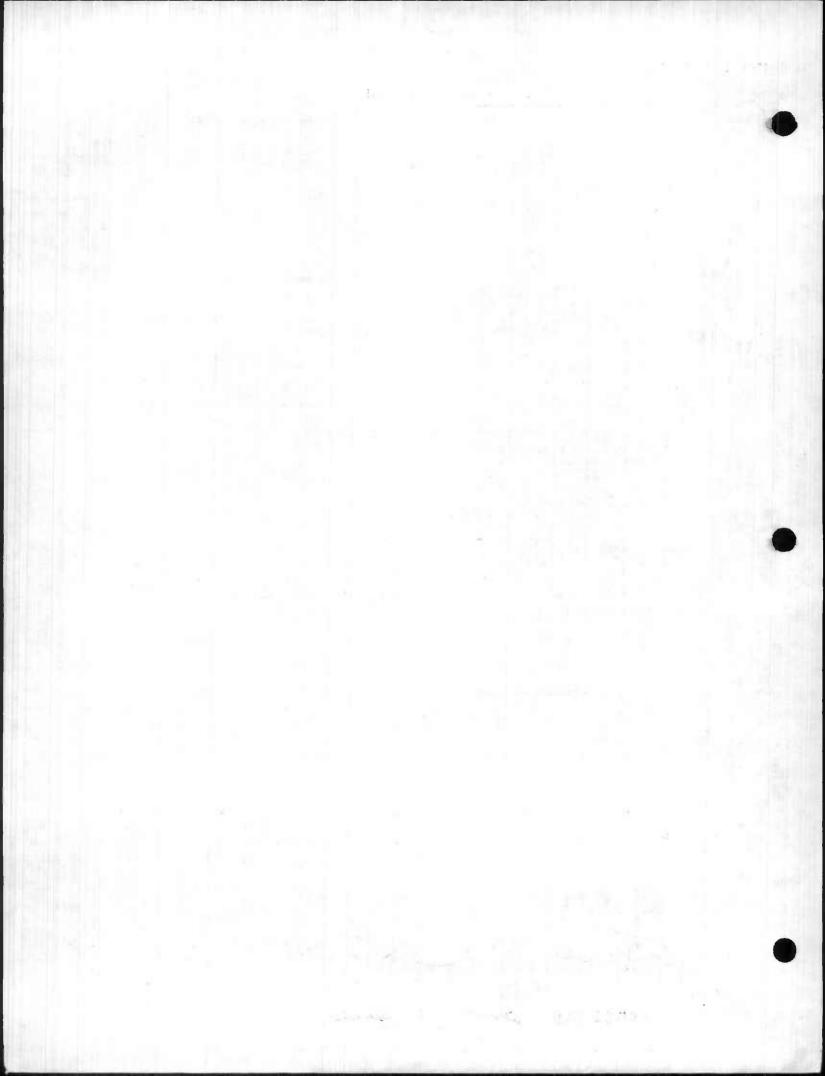
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/32. Registrar's Signature



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| Funeral Director | 217-26-4576 | Sex 1 M 2 F 7. Age (In yrs 81 | s. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day 8/9/19 | h v. Year) 18 | timore 9. Birthplace Country) Maryla | (Stete or Foreign | |
| ath with the Maryland 128 or 2844 show sust be notified at trail Director | Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location | | | | | 10d. Inside City Limits | | | | |
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| and 2 be filed dollars event, 1 | 17. Fathar's Nema (First, Middle, Las | · | 0011 | mp_0yea | 18. Mother's Nam | | Meiden Sumer | | | |
| ore, Marylar ss 1 and 2 should b of Health and Ment filten 27 is resided c other treumstic a | Anthony Malanow 19e. Informant's Name/Ralationship | | 19b. Maili | ng Address (Street | KOSALLE and Number or Rur | Polano | | State, Zip Coo | de) | |
| | Dorothy Elizabet | | | Kenwood | Avenue Ba | ltimore Data | , Maryla | | | |
| Baltimore, | 1X Burial 2 Cremation 3 4 Donation 5 Other (Spec | Removal from State | cometery, cres | natory or other pla ary Cemet | | /21/00 | | | | |
| Balt parmit Depart Import any inj ance | 21. Signature of Funeral Sapvice Licensee 22. Name and Address of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 | | | | | | | | | |
| September 2015 A conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of the conficulty of | 23a. Park Enter the disease, or conshock, or heart failura. List only limited the disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last | a. Due to (| (or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or as a consector or a consector or as a consector or as a consector or as a consector or as a consector or as a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consec | quence of): | east, | Fails Di | sesse | Ön | proximata erval Between erval Between set and Death | |
| ords, P.O. Box 66 requires that the death certific een signed by the attending phould be detached for use as sted by Physician/Mec | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? | | | |
| P deta | Lung Cancer | | | | | 1 Yes 2 No 3 Probably 4 Un | | | y 4 Unknown | |
| ple ple | | | | | | | an autopsy med? | availab | autopsy findings ble prior to etion of cause th? | |
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| of Vita Physician: This certific and director, | 25. Was casa referred to medical examinat? Yas 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) | | | | | | | | | |
| ng Ph ng Ph nneral uneral | 27. Manner of Death 1 | | | | | | | | oute Number, | |
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| State Registrar | FEB 2:2 2000 | 32. Registrar's Sign | | Sparker | / | , | | | | |



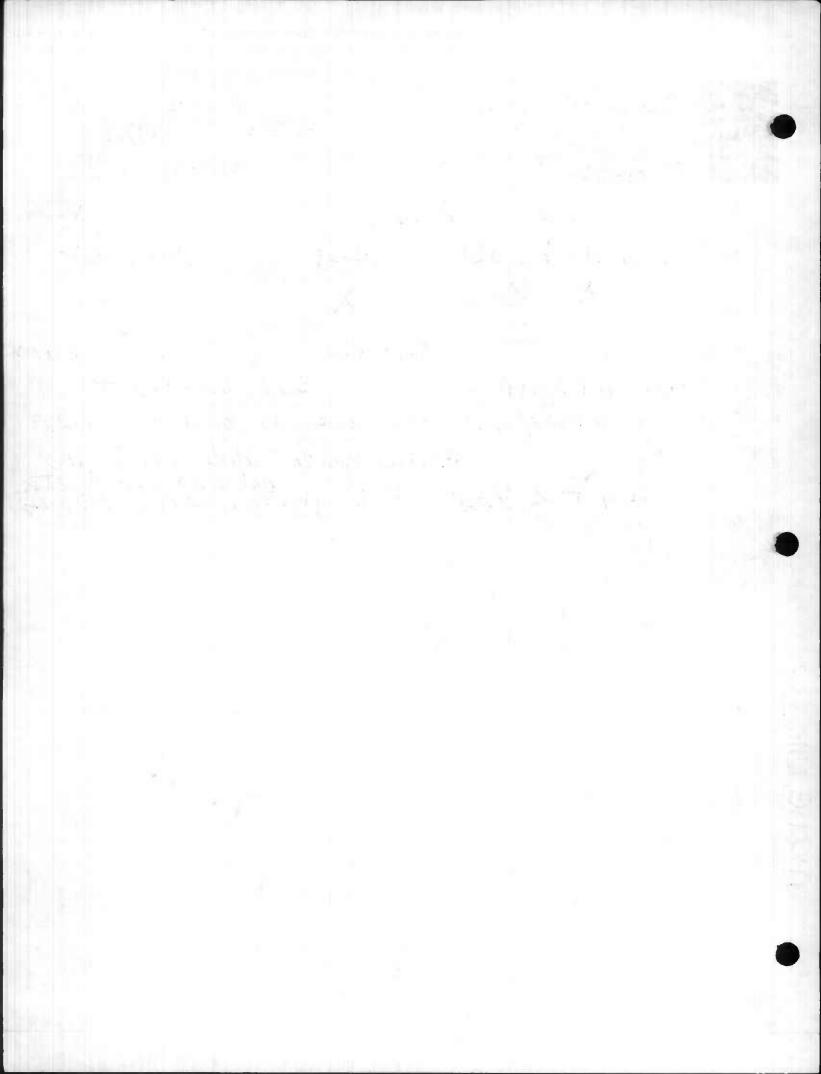
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 05460 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death laude Ellis Mabe **Physician** FEBURAY 16 2000 0846 /Medical 4a. Fecility Neme (If not institution, give street and number)
SAINT AGNES HOSPITAL 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death Examiner 6. Sex 1JXM 2□ F 7. Aga (In yrs. last birthday) Yrs. If Under 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 9. Birthplaca (Stata or Foreign Country) Funerai 232-12-6786 Deys Months Hours Director Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Example: must be notified at 10d. Inside City Limits Baltimore 1 Yes 2 No Director NIA 10e. Street end Numbar 10f. Zip Code 10g. Citizan of What Country? 3032 21223 Stric Inited and 12. Was Decedant Evar in U,S. Armed Forcas? 1 Yes 2 □ No 4 Yes, Giva Yaar or Datas: Race - American Indian Bleck, White, etc. Was Decedant of Hispanic Orlgln? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Navar Married 2 Married 1□ Yes 2 No 21215-0020 Specify Completed by Specify: 3 ☐ Widowed 4 ☐ bivorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry permit. Pages 1 end 2 should be filed within 7; Department of Health and Mental Hygiene. Important: if item 27 is marked other then "na any Injury or other traumatic event, tra Media once. (Specify only highast grade completed) Collega (1-4or 5+) Elemantary/Secondary (0-12) Contractor mprovement Baltimore, Maryland 17. Fathar's Nama (First, Midgle, Last) 18 Mother's Name (First, Middle, Maidap Rober lliam Jane 192 Informent's Name/Ralationship (Type. 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Kland St. 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 defurial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Other (Spacify) 21. Signellyn of Funeral Service Licensed 23e. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediate Causa (Finel Minute disease or condition rasulting in deeth) Examiner Physician/Medical Examiner Quu on La physician and s the burial-transit Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseasa or Injury that Initiated avants rasulting In death) Lest Due to (or es a consequence of): Dua to (or as a consequence of) 12000SIC ecus Part II. Other significant conditions contributing to deeth but not rasulting in tha undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy tindings aveilable prior to complation of cause of death? 24a. Wes an autopsy 1 Yes 2000 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was case rafarred to medical axaminar? 26. Piece of Deeth (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To 1 ☐ Inpatiant 2 DER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 DMatural 2 Accidant 5 Panding Invastigation 1 Yas 2 No hours effer death Director: 6 Could not be datarminad 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homicida 24 hours edicai 1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifier 29c. Licansa number Salceur, ms Holiammad February 16 2000 D40610 30. Nema and address of person who completed cause of deeth (Itam 23a) (Type, Print)

MOHAWMAD SALEEW ST. AGWES HOSP. 900 CATONS AVE. BALTIMORE MD 21229 31. Data tiled (Month, Dey, Year) 32 Registrer's Signetura

DHMH 16 Rev 6/95

Registrar

FEB 2 2 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death 920 ebruary 5,2000 pm GLADYS NELSON 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number raryland Greneral N/A8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours Min Yrs. 213-08-5792 44 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location. 10d. Inside City Limits 1X Yes 2 No Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2305 Druid Hill Avenue 1st flr 21217 14. Rece - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) unknown unknown disabled 18. Mother's Name (First, Middle, Maiden Sum 17. Fether's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md General Hospital 827 Linden Ave Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Signature of Funeral Service Licensee Joseph B. Van Sant 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting In death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evailable prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpetient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Box 68760, requires that the death certificate be Division of Vital Records, or Attending **Physician**

Examiner

Funeral

Director

f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic avant, fre Medical Examens must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if flem 27 is marked othe any Injury or other treumatic avant, bace.

Physician /Medical

Examiner

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Physician/Medical

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Certification:

Medical

29a. Certifier

(Check only one)

To the Hosp within 24 hor To the Fune completely fi

Registrar

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the ceuse(s) end manner as stated.

29d. Date signed (Month, Day, Year)

General

ress of person who completed cause of death (Item 23a) (Type, Print)

maryland 0.40 Taggarse 31. Date filed (Month, Day, Year)

32. Registrar's Signeture FEB22

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖹 🦳 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ay Th Year 3. Time of Death FEBRUARY Dav NEBORSKY EDITH 6:50 pm 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) AUG 10, 1 Birthplace (Stata or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 1 ☐ M 2 🕱 F Months 80 212-12-4496 MD Usual Residence of Dacedani 10a Stata 10c. City, Town or Location 10d. inside City Limits 10b. County 1 No Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5831-A WESTERN RUN DRIVE 21209 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 X No Specify: WHITE Specify. 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANICURIST BEAUTY 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Malden Sumame) JULIUS LAVY BESSTE (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92067 19a. Informant's Neme/Relationship (Type, Print) ROBERT J. NEBORSKY / SON 6064 AVENIDA CUATRO VIENTOS - RANCHO SANTA FE, CA 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State OHEB SHALOM MEMORIAL PARK 2/20/00 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funaral Sarvice Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Votre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS. disaase or condition resulting in death) Due to (or es e consequence of) AINOPPUSAL Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of) that initieted events resulting in death) Last Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown IMBALANCE. ELECTROLYTE 24b. Were autopsy findings available prior to 24a. Wes an autopay performed? UIT. completion of cause of deeth? 2 DINO 1 Yea 20 No 1 Yes 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work?

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a.4 any Injury or other traumatic avent, the Maryland page.

attending physician and for use as the buriel-transit 55 94 2 signed t Deed has certificate

Physician/Medical

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Certification:

1 Natural

2 Accident

3 Sulcida

29a. Certifian

4 Homicide

(Check only one)

The law requires that the death certificete be executed Box 68760. 0 م Division of Vital Records, or Attanding Physician: this funeral After death. Director: A after filled

within 24 hours of edicai completely

State Registrar WW

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ateted.

2 Madical Examiner: On the best of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. Licensa number

Aebruary

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 2000

MD 21133

30. Name and automating person who completed cause of deeth (Item 23e) (Type, Print) NORTHWEST HARISH. YYERA HALLI

5 Pending Investigation

6 Could not be

RANDALLSTOWN

1 Yes 2 No

D 42723.

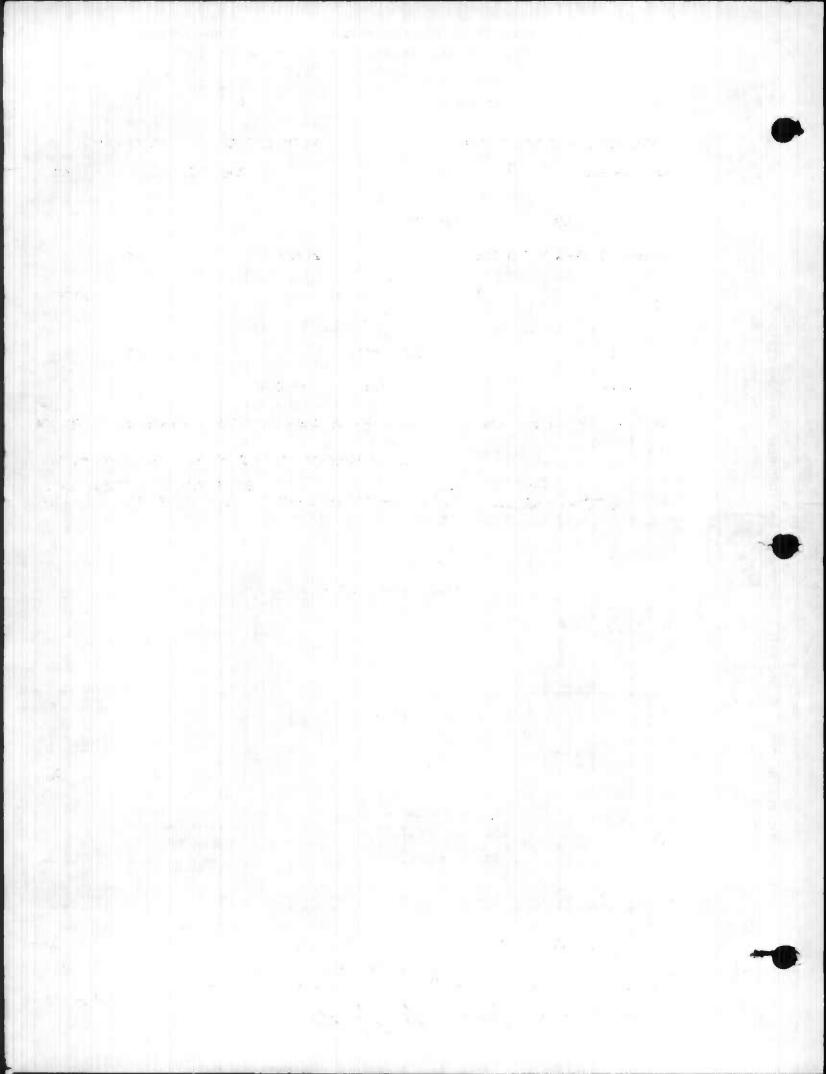
BOSPITAL BITMBS BALTMORE

31. Dete filed (Month, Day, Year) FEB 2 2 2000

29b. Signature and the of certifile

32. Registrar's Signature

28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify)



CS Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. 00-0980-510 LEONARD NEIDHARDT JR. 3/8/00 yg State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 23a, 27, 28a, b, c, d, e, f, per me G781 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Leonard Charles Neidhardt, Jr FEBRUARY 2000 21:43 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Funeral Months Days Hours 1€3M 2□ F 23 213-04-5169 Director May 28,1976 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Phow rai', or items 23s or 28s-f ahov Examiner must be notified at 1 ☐ Yes 2 No Bel Air Director Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 United States deeth Funeral 354 Hunters Run Drive 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 ahould be filed within 72 hours effar of Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Ihen any Injury or other treumatic event, the Medical Examinations. 1 ☐ Yes 2/€ No If Yes, Give Year or Dates: TX3Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 202No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heating and Elementary/Secondary (0-12) College (1-4or 5+) Air Conditioning Technician 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Joann C. Jones 0 Leonard C. Neidhardt, Sr. 19a. Informant's Name/Relationship (Type, Print) Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 354 Hunters Run Drive Bel Air, MD 21015 Mr. Leonard C. Neidhardt, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date ₩3Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Mem. Gdns. 2/21/2000 Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final **ASPHYXIATION** disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificeta be axecuted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physicien/Medical Due to (or as a consequence of) 8 Box (signed by the aid to be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Yes 2□ No Vitai or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? subject put Division After 5 Pending 1 Natural 2/17/00 1 Yes 2 No plastic bag over his head deeth. 2 Accident investigation unknown after deeth Director: 3 Suicide 4 Homicide 6 Could not be determined 28f. Location (Street and Number or Bural Route Number, City or Town, State) 609 Oldham St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital or J
 A hours after
 Funerel Dire
letaly filled in b hame Baltimore, Md. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cortifier To the Hosp within 24 ho To the Fune completaly fi (Check anh onial 290. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ely O.C.M.E. FEBRUARY 18, 2000 and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

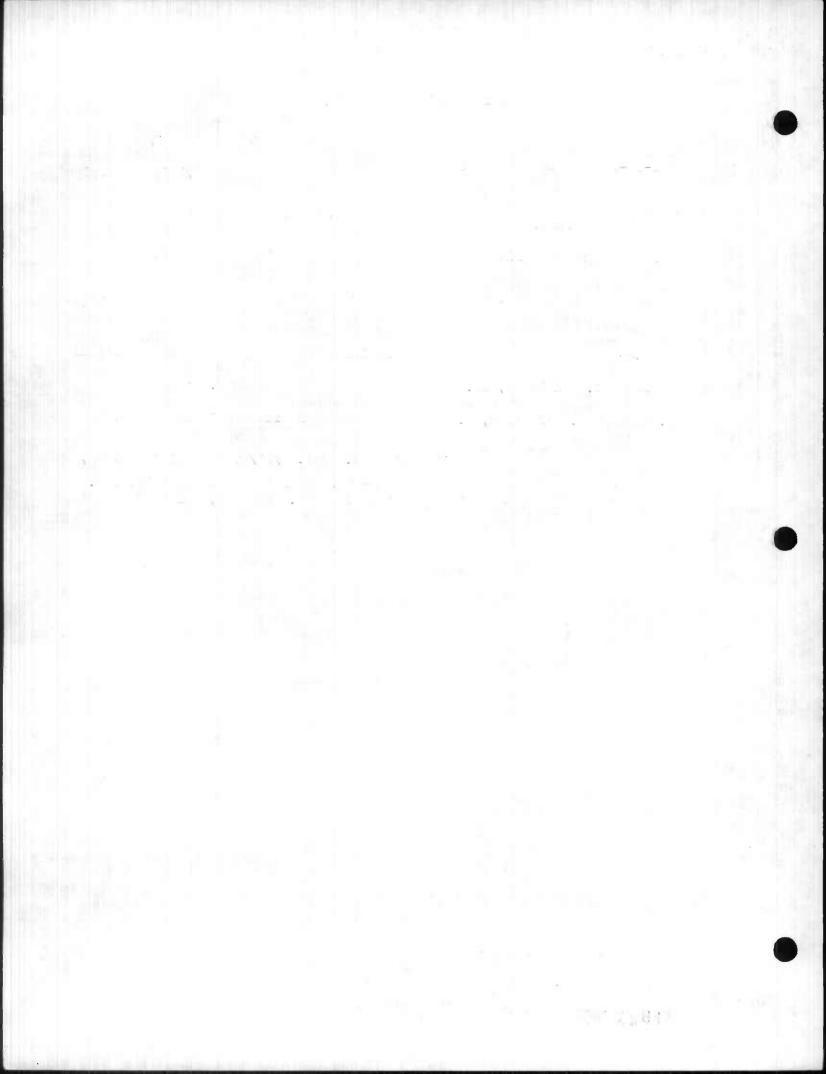
Registrar 5EB 2 2 2000

, UARON LOCKE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Piease Type or Print in Biack indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9:50 PM Ogbuli February 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of 1368 Halstead Road Parkville Baltimore If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Days Min. Hours 1 M 2CKF 215-47-9965 67 Nigeria Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Parkville 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 1368 Halstead Road 21234 Nigeria 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 □ Widowed 4 □ Divorced Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Cecilia Edozie Ignitus Egbuji 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Okey Ogbuli/ Son 4102 Windmill Circle Randalstown, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stele 4 ☐ Donetion 5 ☐ Other (Specify) 3/29/2000 Onitsha, Nigeria Family Compound 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. 21. Signeture of Funerel Service Licensee Zaura C. Hardesty 8717 Green Pastures Drive B. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such a cardiac or respiretory arrest, ahook, or heart feilure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, MD 21286 Approximete Interval Between Onset and Death Immediate Cause (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Merrie 23a

i Hygiena. other than "natural", or item

permit. Pages 1 and 2 should be 1 Department of Health and Mental I important: If leen 27 is marked or any injury or other traumstic eve

Saltimore, Maryland 21215-0020

Examiner The law requires that the death certificate be executed physician s the buria 980 been signed by the atter should be detached for a page 2 or Attending Physician: funeral director. After this

Box 68760.

P.0.

Records.

Division of Vital

death. ne Hospital or Attendi n 24 hours after death ne Funeral Director: A filled in by

Medical completely To the Within 2. State Registrar

Physician/Medical Completed by 8 Certification: To

25. Was case referred to medical examiner? 1 ☐ Yes > No 27. Menner of Death 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 4 Homicide

29a, Certifier (Check only one) 29b. Signeture and title of certifier

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28e. Dete of Injury (Month, Dey Year)

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steled. 29c. License number 29d. Dete signed (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

00

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

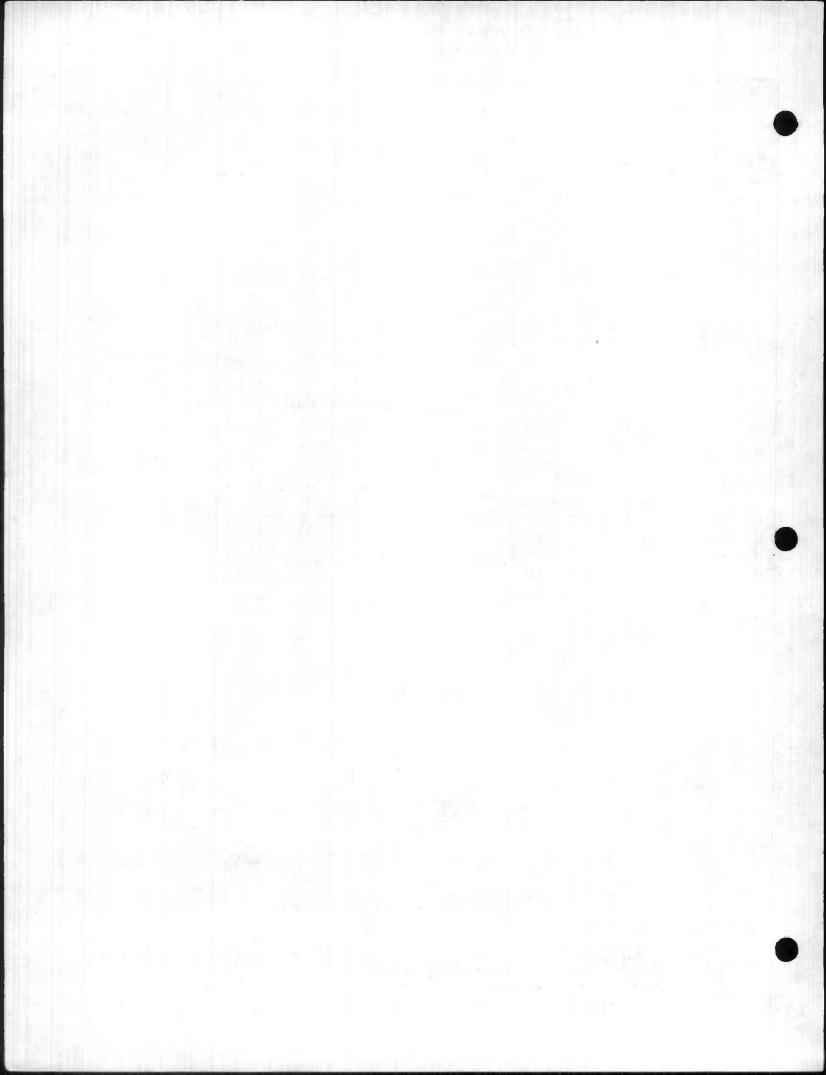
David F. Silver, MD 2411 w. Belvedere Avenue Baltimore, MD

31. Dete filed (Month, Day, Year) FEB 2 2 2000

32. Registre

28c. Injury at Work?

1 Yes 2 No



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Joan F. O'Gara 9:30 pm 18 2000 Teb 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catorsville Center Baltimore Charles fown Care Hours Min. 8. Dete of Birth (Month, Day, Year) Nov. 10, 1920 If Under 1 Yeer 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months 354-01-9287 1 M 2 F 79 Illinois Yrs. **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane #414 21228 U.S.A. 12, Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Joseph Smith Frances Domzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James O'Gara (Husband) 709 Maiden CHoice Lane #414, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20s. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State New Cathedral 2/23/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pull yal Service Licensee Witzke Funeral Homes, Inc. 22. Name and Address of Fecility 1630 Edmondson Avenue, Catonsville, MD 21228 seel Cl 23a. Part1. Enter the disease, or complications that unused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on the line. Approximate Interval Between Onset and Deeth multiple Myeloma Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Naturat 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Examine attending physicien and for use as the burial-transit Box 68760 P.O. been signed by the should be detech certificata or Attending Physicism: Division of After this n 24 hours efter deeth.

He Funerel Director: Afte pletaly filled in by the fun.

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Physician

/Medical

Examiner

Physician

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Examiner

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Funeral

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Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylan Department of Heelih and Mentel Hygiene. Important: if item 27 is marked other than "natural", or herns 23s or 28s-f show sup injury or other traumatic event, the Medical Exercises must be notified at page.

Baitimore, Maryland 21215-0020

edical Physician/M by Completed 8

Certification: To

To the Hosp within 24 hos To the Fune completely fi

edical

Registrar DHMH 16 Rev 6/95

29b. Signature and title of certifier

29c. License number 051051 29d. Dete signed (Month, Day, Year) February 19, 2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Moiden choia land, Catonsville, MD, 2/228 Salazas

31. Date filed (Month, Day, Year)

4 ☐ Homicide

(Check only one)

Andres

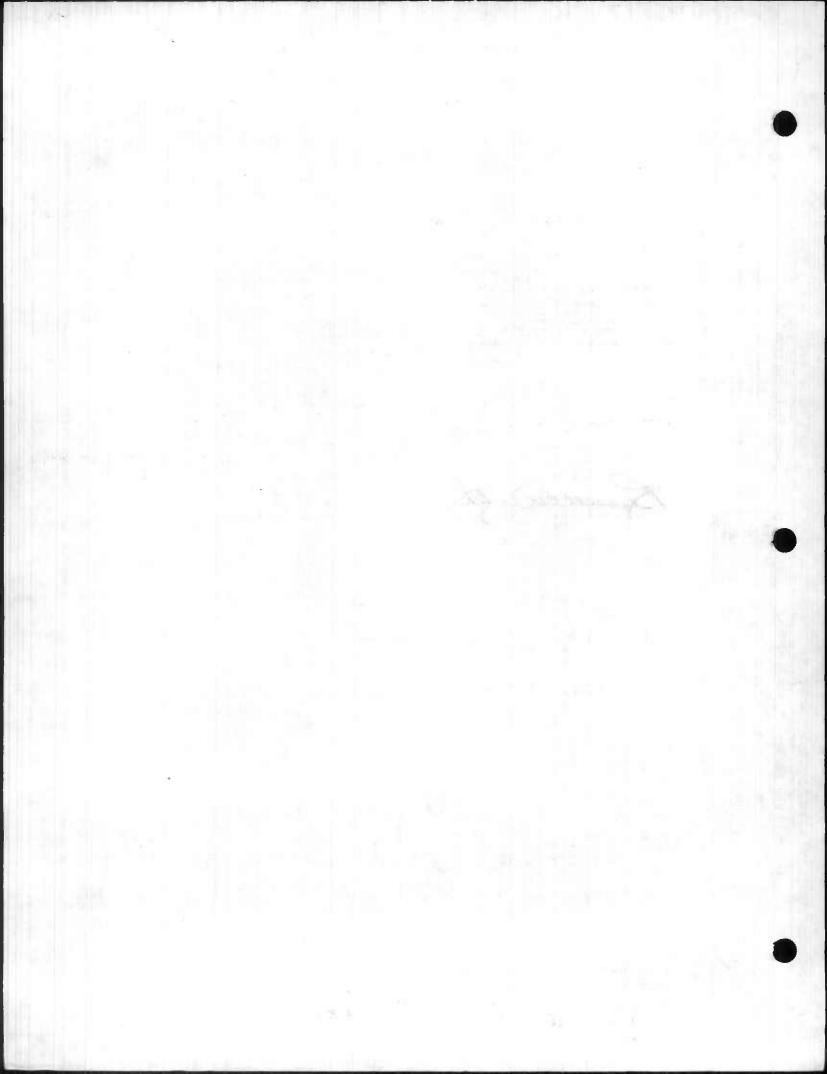
29a. Certified

FEB 2 2 2000

32. Registrar's Signature Mary Mary

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

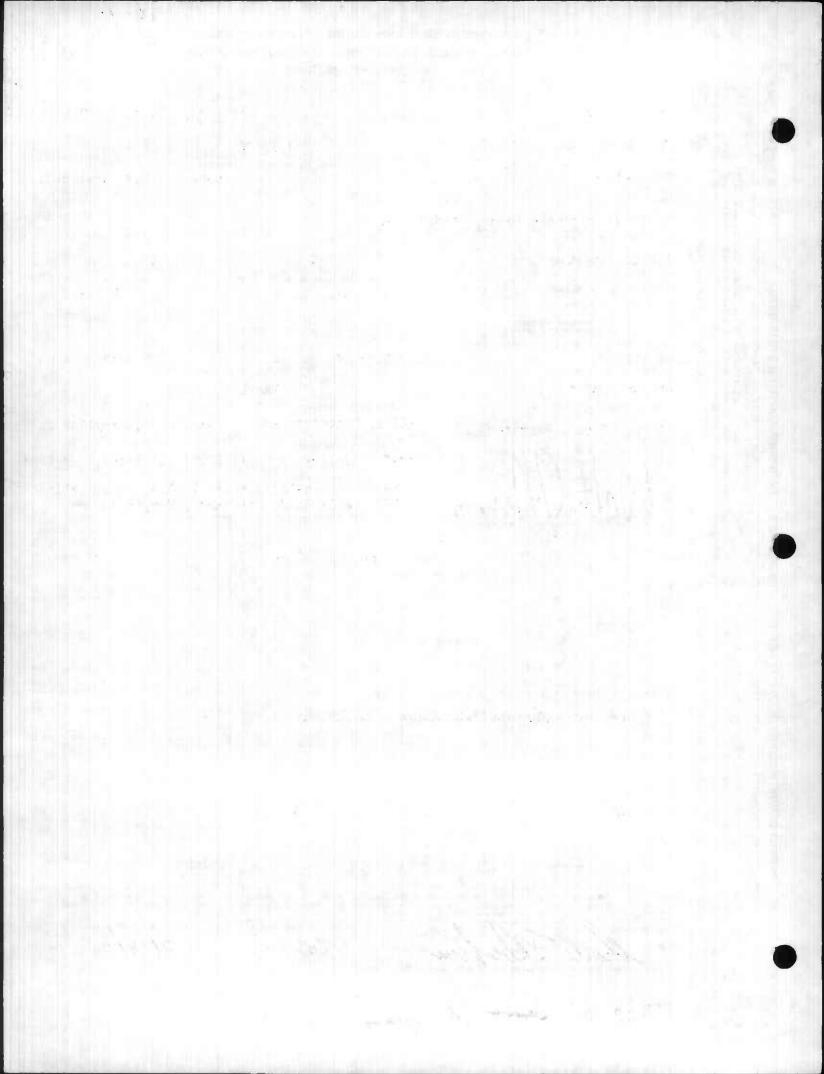


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yaar **Physician** Doris Hilda Pruitt February 17, 2000 cation of Death 4c. County of Death 9.50 AM /Medical 4a Facility Nama (If not Institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Baltimore
If Under 24 Hrs. 8.
Hours Min. Good Samaritan Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ■ M 2X X= Months Deys Director 220-03-4259 January 11,1918 Maryland the Meryland 10a State 10b. County 10c. City. Town or Location show 10d, inside City Limits r than "naturel", or items 23s or 28s-f show the Madical Examiner must be notified at 1 Yes 27 No Maryland Directo Baltimore County Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 E. Kingston Park Funeral 21220 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. semil. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. 1 Yas 2 VNo If Yas, Give Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yas ZMNo Specify: White attimore, Maryland 21215-0020 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Authur Smith Martha Corbin 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 E. Kingston Park Baltimore, Maryland 21220 Sharon_ Fick Daughter 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Byrial 2 □ Cremation 3 □ Fi b St. Mary's Cemetery 2/21/2000 Baltimore, Maryland 5 Other (Speed (iy) 21. Signatu 22. Nama and Address of Facility ns. of Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland and death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Final Long meinoms 6 mos diseasa or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 7res 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE LINE DISCOSES þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Wes an autopsy 1 ☐ Yes 2 Dolo 1 □ Yas 2 □ No certificate Division of Vital or Attending Physician: efter deeth. Director: After this certific 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending Investigation 1 ☐ Yes 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examinar: On the best of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title Certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 railer 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 1601 E. Belvedere Ave. Good Samaritan Nursing Center Hoesch Charles Baltimore, Maryland 31. Date filed (Month, Day, Year) FEB 2 2 2000 32. Registrar's Signature State Registrar

9HMH 16 Rev 6/95

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death Month FEB; Year IRENE PLICHTA 2000

05467

3. Time of Death

7:45 PM

Physician /Medical Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland "natural", or items 23s or 28s-f show idical Examiner must be notified at

Baltimore, Maryland 21215-0020

Physician Examiner

Othe Hospital or Attending Physician: The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

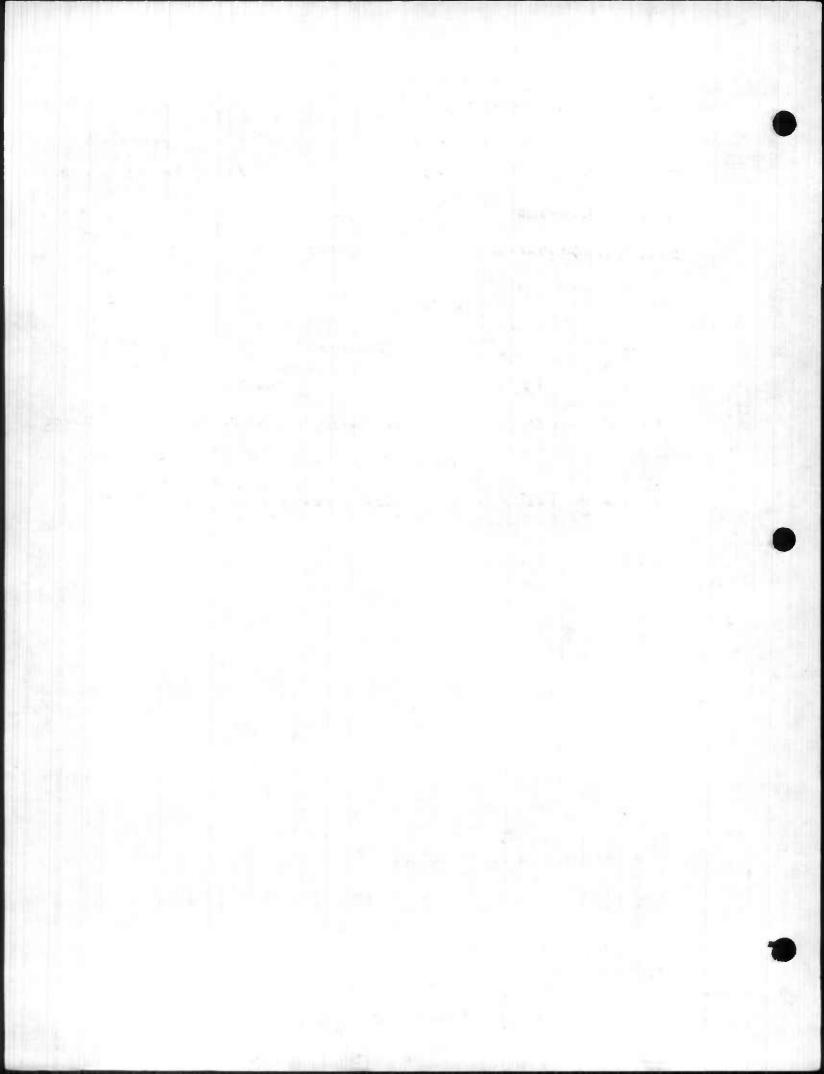
> State Registrar

DHMH 16 Rev 6/95

aRK 31. Dete filed (Month, Day, Year)

| MARINER HEALTH of | | | FA1/57 | o N | HA A I | 2 for D |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------|--------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------|
| 5. Social Security Number 143-05-0323 Usual Residence of Decedent | 7. Age (In yrs. last birth | hday) If Under 1 Y Months Di | ear If Under 24 Hrs ays Hours Min. | | | 9. Birthplace (State or Foreig Country) NEW YORK |
| 10a. Slete 10b. County | 10c. City, Town | or Location | | | | 10d. Inside City Limits |
| MD HARFORD | FOR | EST HIlls | | | 1 ☐ Yes | |
| 10e. Street and Number | | 10f. Zip Co | ie | 100 | | fhat Country? |
| 2246 PHillips Mill A | (D) | | 050 | | USA | |
| 1 Never Married 2 Married 1-8 Yes | Decedent Evar in U,S. If Forces? es 2 No Give or Datas: 1467-1954 | 13. Was Decedent If Yes, apecify (| of Hispanic Origin? (S Cuban, Mexican, Puer No Specify: | Specify Yes or No- to Rican, etc.) | | - American Indian, k, White, etc. |
| 15. Decedent's Education | 16a. | Decedent's Usual Or | cupation | 16 | b. Kind of Bu | siness/Industry |
| (Specify only highest grada complet Elementary/Secondary (0-12) Colleg 2 | (1-4or 5+) | SECRETA | one during most of wo ntired) 14) | aking = | THSUR | ANCE |
| 17. Father's Name (First, Middla, Last) | | | 18. Mother's Na | me (First, Middle, Ma | iden Sumam | θ) |
| UNKNOWN REI | D | | UNK | NOWN | | |
| 19a. Informent's Name/Relationship (Type, Print) | 19b. | Mailing Address (St | reet and Number or R | ural Route Number, (| City or Town, | State, Zip Code) |
| DIANE PLICHTA (NIE | | | llips Mil | RDS FAI | ISTON 1 | M). 21050 |
| 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal fr | cometen | Disposition (Name of y, crematory or other | place) | Date 20 | c. Location - | City or Town, Stata |
| 4 Donetion 5 Other (Specify) | METR | O CREMA | TORY | 2/21/21 b | BALTI | o. Md. |
| 21. Signature of Funeral Service Licensee | 1 | DELLA N | ddress of Facility OCE + So N- HILH ST. | · FUNCESI | Home | 5 |
| 23a. Part1. Enter the disease, or complications th | at caused the death. Do n | | | | | Approximate |
| shock, or heart failure. List only one cause of | on aach line. | | | | | Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | Theyo Scled Due to (or as a c | consequence of): | rdiovas | cular c | Liseas | e ten yer |
| Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events | Due to (or as a c | consequence of): | | | | 1 |
| that initialed events resulting in death) Last | Due to (or as a co | onsequence of): | | | | |
| - 0. | | | | | | 1 |
| Part II. Other algoriticant conditions contributing t | o death but not resulting in | the underlying cause | e given in Pert I. | | | stribute to the cause of death |
| | | | | 24a. Was an performe | autopsy ad? | 24b. Were autopsy findings available prior to completion of cause of death? |
| | | | | 1 🗆 Yes | 2 No | 1 ☐ Yes 2Û No |
| 25. Was case referred to medical examiner? | | | | ath (Check only one) | | |
| 1 ☐ Yas 2 ☐ No Hospitel: 1 | | patient 3 DOA | Other: 4 Nursing I | lome 5 ☐ Residen | ce 6 Othe | or (Specify) |
| 1 ☑ Natural 5 ☐ Pending (A 2 ☐ Accident investigation | ate of Injury Month, Dey Year) 28b. Ti | njury | Injury at Work? 1 Yes 2 No | 28d. Describe how | injury occurr | ed |
| | ace of Injury - At home, far uilding, etc. (Specify) | m, street, fectory, off | ice | 28f. Location (Stre City or Town, | et and Numb State) | er or Rural Route Number, |
| 29e. Cartifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and medical Examiner: | the best of my knowledge, e basis of examinetion end nanner stated. | death occurred at the | e time, date and place ny opinion, death occ | e, and due to the cau urred at the time, date | se(s) and ma e and place, a | nner as stated. and due to the cause(s) |
| 29b. Signature and title of certifier | 60 | | ense number | | | i (Month, Day, Year) |
| Markha | 1 (d 4) | | d355 | 22 1 | Februa | 14 20, 2000 |
| 30. Name and address of person who completed o | ause of death (Item 23a) (1 | Type, Print) | Be | I Air | Maria | 14 20, 2000 and 21014 |
| 21 Date filed (Month Day Year) | 2 IV Q / T | h MYVE | ine of | 1 // 18 | 14/9/ | 400 01019 |

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) beats See 19, 2000 -6 4b. City, Town, or Location of Deeth 45 County of Death 4a Facility Neme (If not institution, give street and number) 7. Age (In yrs. lest birthdey) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FC 20, 1929 MERCY 5. Sociel Security Number Birthplece (State or Foreign Country) 6 Sex 1XM 2□ F 150-14-4727 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No UNION N. J. KAHWAY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 293 EAST HAZELWOOD AVENUE USA14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. Armed Polices: 1 2 Yes 2 No KOREA If Yes, Give Year or Dates: 1951-1953 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced BLACK 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PUBLISHING CO. GENERAL MANAGERAND ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) GEORGE WASHINGTON ROBERTS RICHARDSON 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 293 EAST HAZEL WOOD AVENUE RAHWAY N. J. 07063 lace of Disposition (Name of Date 20c. Location! City or Town, State MARGARET ROBINSON ROBERTS (WIFE) 20b. Piace of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal trom State ROSEHILL CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 02-23-00 LINDEN, NEW JERSEV 22. Name and Address of Facility JOSEPH It. BROWN JR. FUNERAL HOME 21. Signature of Runeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximate Interval Between Onset and Death myocardial in forction ary Antery disease Immediate Cause (Final disease or condition resulting in deeth) (or as a consequence COVONAVU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown laucoma 24b. Wera autopsy tindings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time ot 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

멅 physician s the burial Box 68760. P.0 Division of Vital Records, after death Director:

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Completed BB 2 Certification:

Physician/Medical To the Hospital within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Directo

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Funeral

Director

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"natural",

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "neary injury or other trainment.

Physician

/Medical

Examiner

traumetic event, the Medical Examiner must be

the Maryland

Baltimore, Maryland 21215-0020

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and/address of person who completed cause of death (Item 23e) (Type, Print)

Place

Balhniere MD

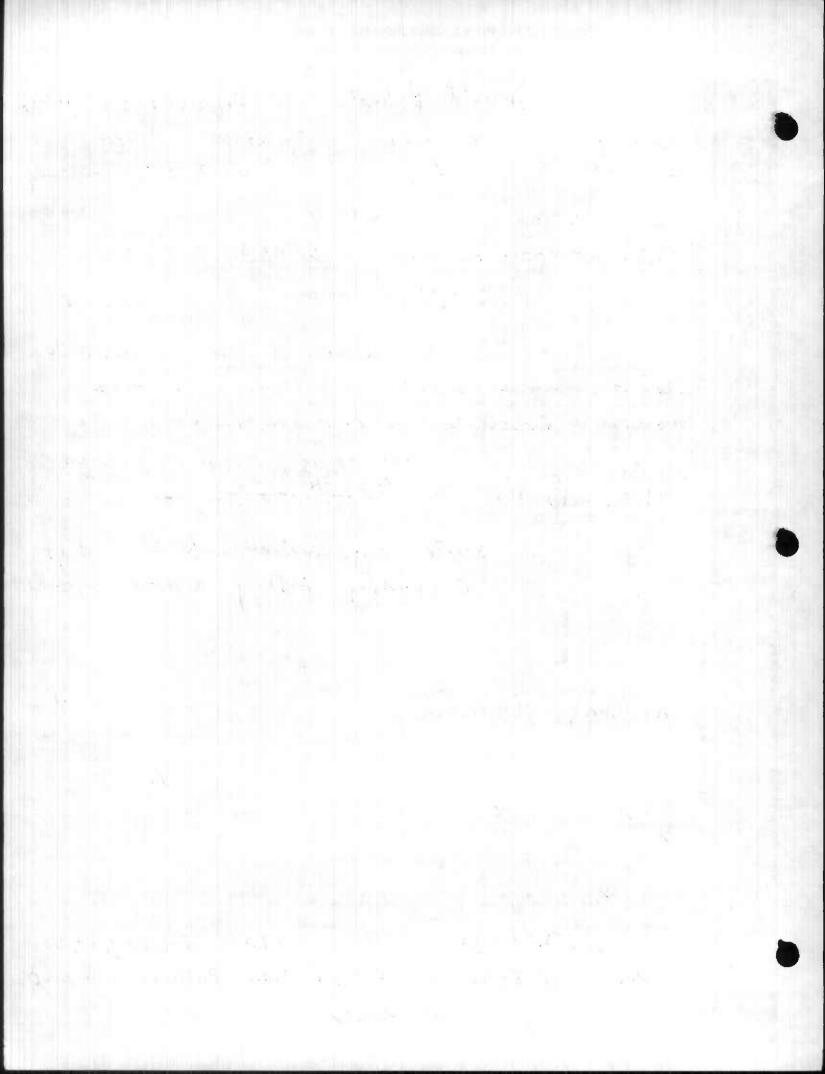
Registrar

31. Date tiled (Month, Day, Year)

29a. Certifier (Check only one)

FEB22

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** GRACE M RYAN FEBRUARY 18 2000 cation of Death | 4c. County of Death 0.15 AN 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIM IRE I H Under 24 Hrs. 8. Date AGNES If Under 1 Year 8. Data of Birth (Month, Day, Year) Aug 13 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Days Months Hours Country) West Virginia 1 M 2 F 218-07-4300 Yrs 86 Director **Usual Residence of Decedent** death with the Menyland 10a Stale 10h Count 10c. City, Town or Location 10d. Inside City Limits ehow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD NZA Baltimore 1 Yas 2 No Director 40e Street and Number 10f. Zip Code 10a. Citizen of What Country? 401 D Swan Ave. 21229 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Statue 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black White atc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baitimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify I Hygiena. other than "natural", c 2 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental hygiens Important: If Item 27 is marked other that any injury or other traumatic avant, that page. Homemaker own home 1vr 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Be James H McClung Marie Sturbois 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Carl Meil / nephew 1102 Ryegade Road Baltimore Md. 21286 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from Stata Metro Crematory Inc. 2/19/2000 Balitmore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. the mode of dying, such as cardiac or respiratory arrest, estions that caused the death. Do not enter Approximate Interval Between Onset and Death e, or cont List only **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical MONTHS OBSTRUCTIVE PNEUMONIA Examiner Examiner 2 MONTHS CANCE UNG sician end burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) 2 MONTHS physician es the burial Box 68760. CAN (E OLON Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco uag/contributa to the causa of death? signed by t 1 Yaa 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 N No 1 Yes 1 ☐ Yas 2 ☐ No or Attending Physician: after death. Director: After this certific funeral director, 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 1 Yas 2 No 1 D Inpatient 2 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number V 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

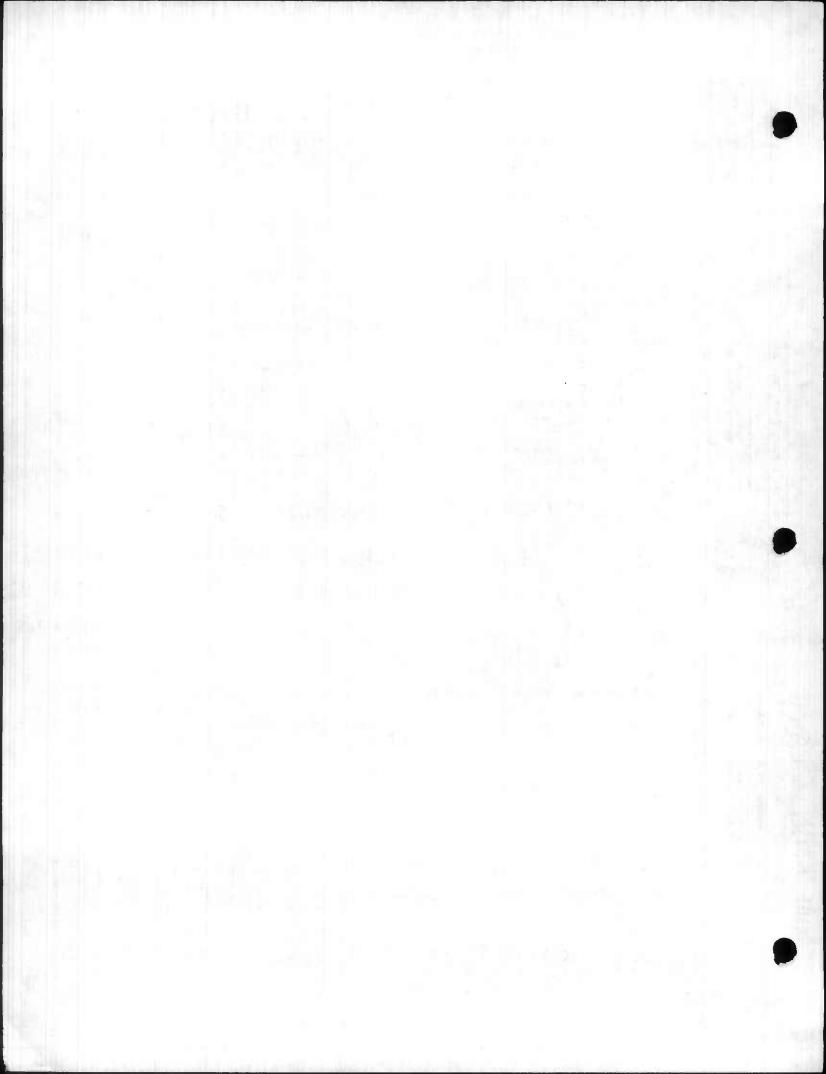
State Registrar DR BARIFI C 31. Data liled (Month, Day, Year)

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32. Registrac's Signature



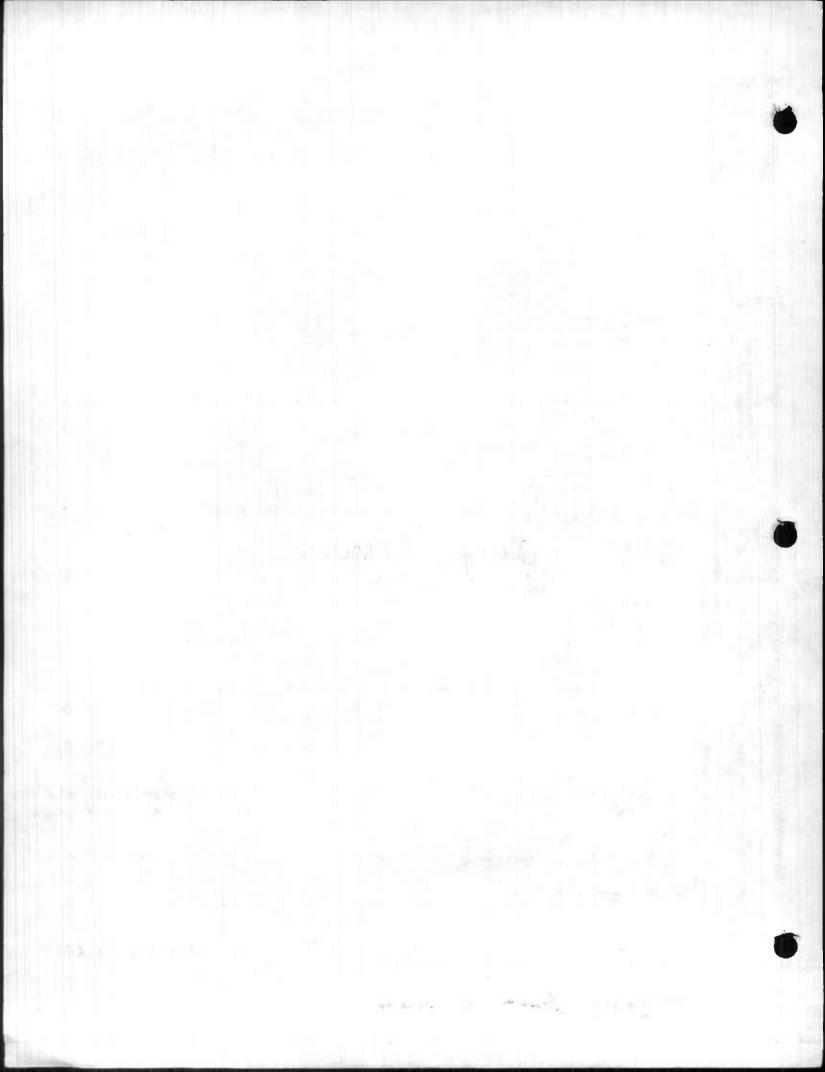
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05470. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 250 **Physician** John Elisha Rice FEBRUARY 21, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris @ Mercy Baltimore If Under 24 Hrs. If I Inder 1 Year 8. Data of Birth Nov 1, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Tennessee Davs Hours 410-34-4355 17€ M 2 F 72 Director **Usual Residence of Decedent** permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Martal Hygiene. Important: If them 27 is marked other than "natural", or theme 23e or 28e-f show leny injury or other treumatic event, the Healton Examination of the Property of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of the Martal Control of 10b. County 10c. City, Town or Location 10d. Insida City Limits MD 1 ☐ Yas &☐ No Anne Arundel Millersville 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 8400 Veterans Highway 21108 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forces? 4.0.7.6 14. Race - American Indian, 11 Marital Status Armed Forces? 1949/ 1 1 Yes 2 No 1949/ If Yes, Give 1954 Year or Dates: 1954 Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☑-Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attendant Service Station 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Dedrick Rice Ethel Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Phil Harding/nephew 162 Masters St., Erwin, TN 37650 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/21/00 Baltimore, MD Cremation Society of Maryland, Inc. 21. Signature of Funeral Service (Cognise Thomas Gregor Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burla Box 68760 Physician/Medical Due to (or as a consequence of): The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably Winknown be datac þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 : 2000 1 Yas 2 No certificate or Attending Physician: 25. Was case referred to medical axaminer? 26. Place of Death (Check only ona) STE //A 88 MARIS AT MERC Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) HOSPICE Certification: To 1 Yes 2 Vic 1 | Inpetient 2 | ER/Outpetient 3 | DOA 耆 28d. Dascribe how injury occurred 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Natural 5 Pending 1 Yes 2 No 24 hours after death. Fumeral Director: A investigation 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

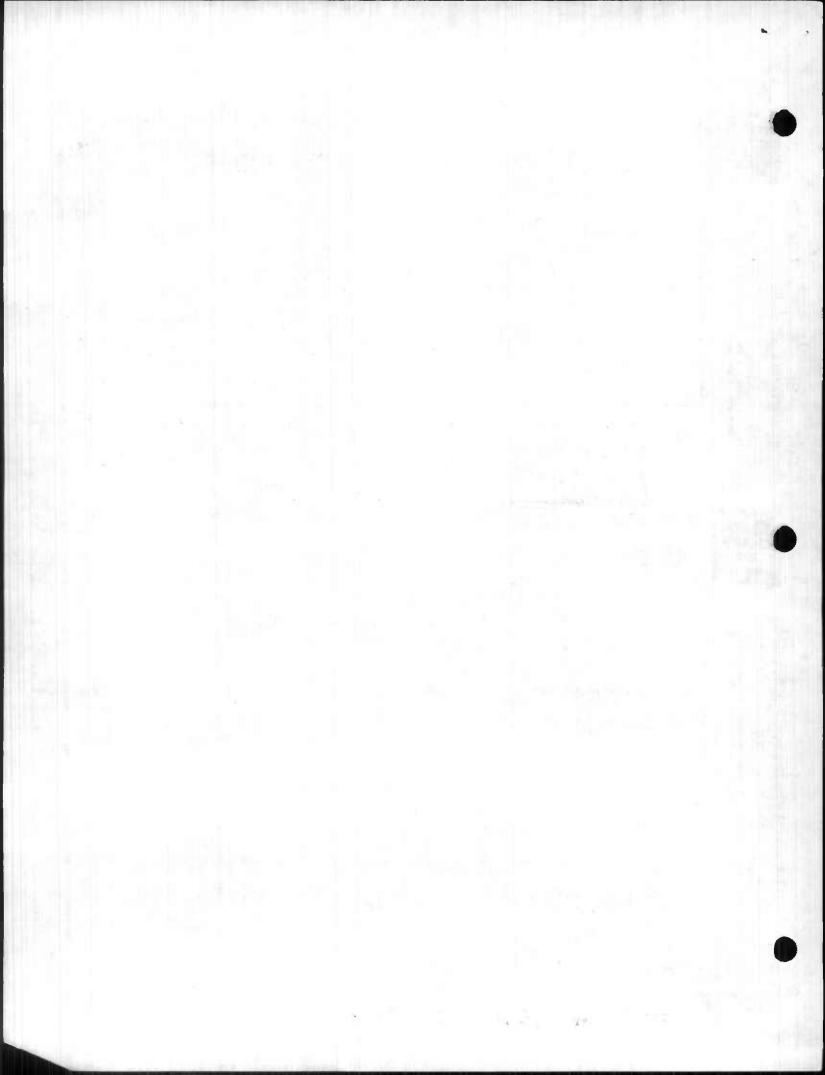
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the F 8 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person BAHiMORE Md 21202 31 Date filed (Month, Day, Year) FEB 2 2 2000 32. Registrar

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2309 Elizabeth Rohrback 4b. City, Town, or Location of Death 1, 2050' 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number Examiner N/A p.tal 11 Ultimor If Under 24 Hrs. more 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral 10 M 20 F Months Days Min Hours Maryland 216-48-3658 11,1946 53 December Director Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location should be filled within 72 hours after death with the Manylan nd Mental Hyglena. marked other than "natural", or forms 23a or 28a-f ahow umatic event, tra that call Exercise must be notified as 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Pikesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 709 Cloudyfold Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White S 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)
3 Years L.P.N. Nurse Sinai Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Charlotte Frances Jeffery Ralph Mithcell Burgee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Lawrence A. Rohrback -Husband 709 Cloudyfold Drive Pikesville, MD 21208 mportant: If Iham 27 my injury or other to altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/21/00 Saints Cemetery Reisterstown, MD 21. Signature of Fune at Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD Ma. Part1. Epthr the Second m, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final WOIDSATINI disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine HYPERTENION be assecuted physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PERSPHREAL NISEASE. Box 68760. VAIWLAR Physician/Medical Due to (or as a consequence of) that the death certificate US0 28 for use as signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 210No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2(VNo 1'O Inpetient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 DNatural 5 Pending death. 1 Tyes 2 No 2 Accident after deatl 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in • Hospital of 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Auten TOOD Wr 100m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



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| 219-18-2 | 219 - 18 - 2235 ^{1፟፟፟፟፟፟፟ M 2□ F 7} | | (In yrs. lest | birthdey) Yrs. | If Unde Months | Days | | 24 Hrs. Min. | 8. Date of Bird (Month, Da April | , 1925 | 9. Birth Cou | nplace (Steta or Foreign Intro) MD | | |
| Usual Residence of 10a. Stete | 10b. Cou | | | | 10c. City, T | ity, Town or Location | | | | | | | 10d. Inside City Limits | |
| MD | MD Baltimore I | | | | В | Baltimore | | | | | | 1 ☐ Yes 20 No | | |
| 10e. Street and Number 113 B Cross Keys Road | | | | | 10f. Zij | Code | 21210 10g. Citizen of What Country? | | | untry? | | | | |
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| Georg | e Pit | ts Ral | leigh | | | | | | | M | lildred | Warfiel | Ld | |
| 19a. Informant's Name/Ralationship (Type, Print) GBMC | | | | | 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) | | | | | | | | | |
| 20a. Method of Disposition 20b. Pl | | | | 6701 N. Charles Stree lace of Disposition (Name of ematary, crematory or other piece) | | | | Date Town | Towson, MD 21204 20c. Location - City or Town, State | | | | | |
| 21. Signature of | osepn La | ic BLicensee | n Sar | it | 1 | | tate alti | | | Boar 212 | d 655 W 01 | . Balti | more | Street |
| 23a. Pert1. Enter shock, or hea | the disease art failure. I | or complica List only one | tions that cause on | caused (| ne death. [| o not ent | er the mod | de of dy | ing, such as | cardiac | or respiratory e | rest, | | Approximate Interval Between Onset and Death |

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If frem 27 is arrefed other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, fire section Exameter man to notified at

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completally filled in by the funeral director; p.

Division of Vital Records, P.O. Box 68760.

State Registrar

29b. Signature and title of certifier

FEB 2 2 2000

General

30. Nama and address of person who completed ceusa of daath (Itam 23a) (Typa, Print)

MARTIN C. CLOWSE, M.P. 6565 N. CHHOUSS ST., STEYU8, Baltimore MM ZIZUY

31. Date filed (Month, Day, Year)

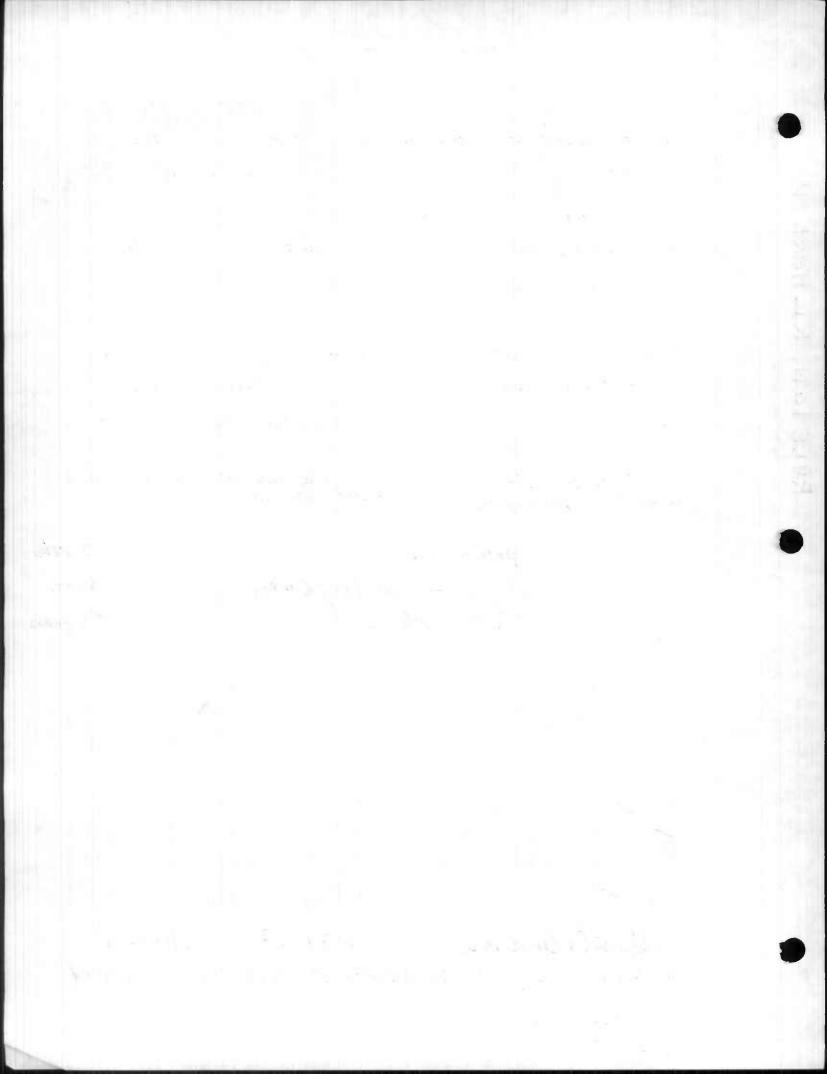
32. Registrar's Signature

29c. License number D 5 4 9 3 7

24b. Were autopsy findings aveileble prior to completion of cause of death?

1 Yes 2 No

29d. Date signed (Month, Day, Year)



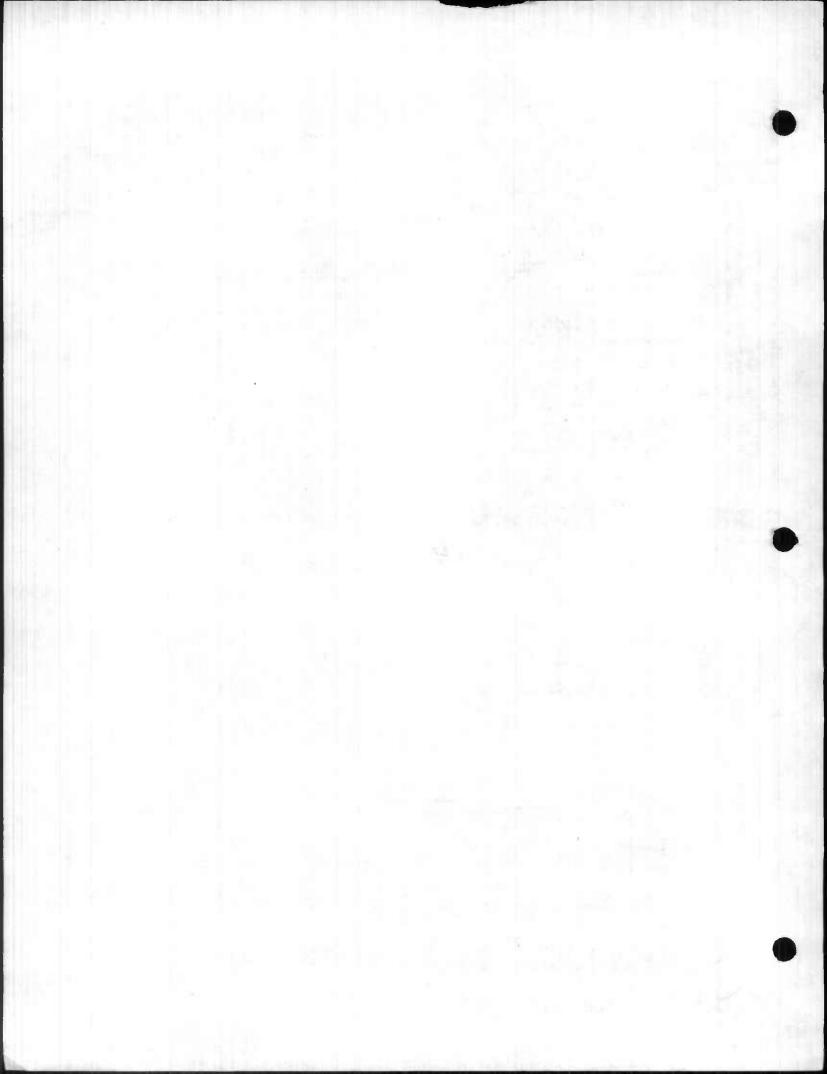
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| State of Maryland / Department of Health and Mental Hygiene | 1 |
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05473 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20, 2000 **Physician** 8:30 February AM John G. W. Robey, Jr. /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3300 Benson Avenue (apt. #406) Baltimore Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) November 5, 1923 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Country) Maryland 18 M 2□ F 219-12-8121 76 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Marylar r than "natural", or hama 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 □ No Directo Baltimore Maryland Baltimore 10g. Citizen of What Country? 10a Street and Number 10f Zin Code 21227 United States 3300 Benson Avenue (apt. #406) Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 72 hours after 1 2 Yes 2 No If Yes, Give Year or Detes: 1943-1945 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify 20 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Sales Representative Sales permit. Pages 1 and 2 should be the Department of Health and Mental Ply Important: If them 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be Helen Goss John G.W. Robey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 935 Wilton Drive, Baltimore, Maryland 21227 Barry Robey-Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □Removal from State Baltimore National Cemetery 2-25-00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Euneral Service Libens 22. Name end Address of Fecility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229 ausor ications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final years disease or condition resulting in death) Examiner Due to for as a consequence of): Examin attending physician and for use as the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): P.O. 23b. Did tobacco usa contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 12 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 89 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 70 After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending Natural 5 Pending investigation spital or Attendir cours after death. heral Director: Af filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di edical Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner stated. 29a, Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51018 22/ 20 rulo, MD onglas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

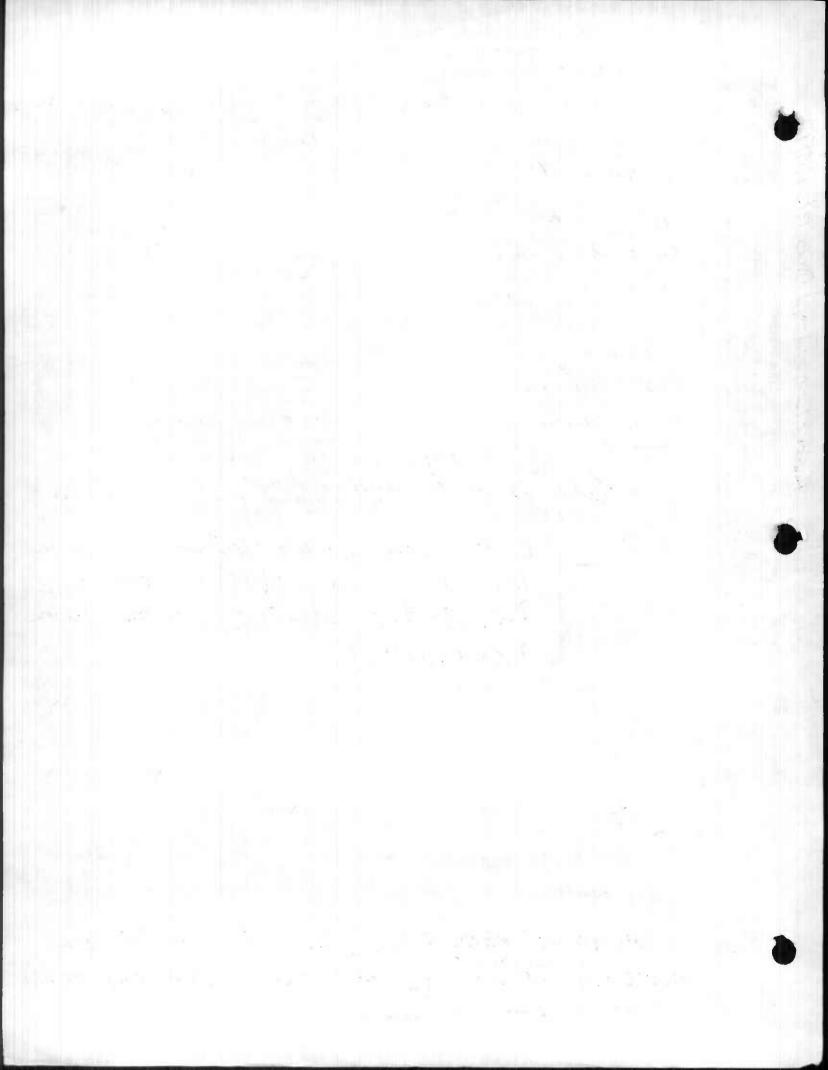
Douglas L. Pinto, MD 3421 Benson A suite 230, Battimare, MD 21227 3421 Benson Ave, 31. Date filed (Month, Day Base) 2 2000 32. Registrer's Signature State Registrar

DHMH 16 Ray 6/95



Robertson, Floyd (BOB 12/24/1919)

| | | yland / Depa | artment of I | Health and Me | ental Hygie | ene () () | 054 | 74 | |
|--------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------|-----------------------|----------------------------------------------|--------------------------------------|------------------------|------------------------------|-----------------------|--|
| AMEND#20a PER F.H. G78 | | B Cei | rtificate of | | | . No. | | | |
| 1. Decedent'a Name (First, Middle, L | 1 1 | tern | | | 2. Dale of Death Month | A | Year | me of Death | |
| Ploy | <u> </u> | rison | | 4h City Town or Los | 02 - | 19 | | 7.3044 | |
| 4a Facility Name (If not institution, g | . / | | | 4b. City, Town, or Loc | der . | 4c. County of | Death | | |
| | Sex 7. Age (II | In yrs. lest birthday) | If Under 1 Year | | 8. Date of Birth | NA | 9 Birthplace (S | Itate or Foreign | |
| 0.1 - 0 - 00 | 10XM 2□ F | Yrs. | Months Deys | | (Month, Dey, Y | ear) | 9. Birthplace (S Country) | MA | |
| Usual Residence of Decedent | | 00 | | | 12-24. | -19 | | 19 | |
| 10e. State 10b. County | | Oc. City, Town or Lo | cation | | | | | ide City Limits | |
| Md 1 | VA | Baltin | 1 ore | | | | 1.8 | Yes 2□No | |
| 10e. Street and Number | | | 10f. Zip Code | | 100 | . Citizen of Wh | nat Country? | | |
| 5409 Price | Avenue | | 21 | 215 | | U. | S.A | | |
| 11. Marital Status | 12. Was Decedent Eve | er in U,S. 13.1 | Was Decedent of | Hispanic Origin? (Spectan, Mexican, Puerto F | cify Yes or No- | | - American Indi | an, | |
| 1 Never Married 2 Married | 1 Yes 2 No | | 1 ☐ Yes 2 😿 No | | ncarr, etc.) | | White, etc. | | |
| 3 ☐ Widowed 4 ☐ Divorced | Year or Dales: | | | | | Specify: | DAG- | | |
| 15. Decedent's (Specify only highest g | Education rade completed) | (GIVA | KING OF WORK GONE | pation COMP | 9 16 | b. Kind of Bus | iness/Industry | lun | |
| Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retire | 9d) | | | | | |
| (oth grade | NA | 4 | | T | /F: | 14 0 | 1 | | |
| 17. Felher's Name (First, Middle, Las | | | | 18. Mother's Neme | 0 | , | / | | |
| Elisha Rober | | | | Irene | | rpbel! | | | |
| 19e. Informant's Name/Relationship | | | 6 | et end Number or Rural | _ | | | | |
| | son-Brother | | / / | e Avenu | | to, and | 2/2/5 | | |
| 20a. Method of Disposition 12 Burial 2 Cremetion 3 | □Removel from State | 20b. Place of Dispo cemetery, crea | metory or other pl | | | 0 | City or Town, SI | A | |
| 4 □ Donation 5 □ Other (Spec | rify) | Metro | Cremar | | -18-00 C | atons | suille,1 | Md | |
| 21. Signeture of Funeral Service, Lic | ensee | 1 2 | 2. Name and Addr | ess of Facility | + | | , | | |
| / Yale | 11 car | en M | 4300 | wabash | Avenue | Bal | to, nd : | 21215 | |
| 23a. Part1. Enter the disease, or co shock, or heert failure. List on | mplications that caused the | e death. Do not en | ter the mode of dy | | | | Appro | oximate al Between | |
| 311001, 01 110011 1411010. E. 31 0111 | | | | | L + | | Onse | and Death | |
| Immediale Cause (Finel disease or condition | Carcil | noma | i at | 76057 | ale | | 6 | SYC | |
| resulting In deeth) | 9. | e lo (or as e conse | Quence of): | 1 | . 1 | + | | | |
| | TRESID | nerax | Va | scula | rH | seas | e 10 | 29/05 | |
| Sequentially list conditions, if any, leading to immediate | Du | e to (or as a conse | quence of): | 1 | P | | | | |
| cause. Enter Underlying | Decu | 151TU | S U | 100 | 9/50 | accur | 7 10 | OMO | |
| Ceuse (Disease or Injury that initialed events resulting In death) Lest | Due Due | e to (or as a consec | quenca of): | | 7 | | | | |
| | Theu | mor | 1a | | v | | | | |
| | 0 | | | | | | 1 | | |
| Part II, Other significant conditions | contributing to death but n | not resulting in the u | inderlying ceuse g | jiven in Pert I. | 23b. Did tob | acco use cont | tribute to the c | ause of death? | |
| | | | | | 1 Yes 2 No 3 Probably 4 Inknown | | | | |
| | | | | | | | | | |
| | | | | | 24a. Was an performe | autopsy ed? | 24b. Were aut evailable | prior to | |
| | | | | | | | of death? | on of cause | |
| | | | | | 1 ☐ Yes | 20 No | 1 ☐ Yes | 2□ No | |
| 25. Was case referred to medical | | | | 26. Place of Deeth | (Check only one |) | | | |
| examiner? | Hospital: 1 ☐ Inpatient | 2 ER/Outpatie | nt 3 DOA | ther: 4 Nursing Hon | ne 5 Residen | ca 6 □Othe | r (Specify) | | |
| 27. Menner of Death | 28e. Date of Injury (Month, Dey Y | (ear) 28b. Time of Injury | 28c. Inj | | 28d. Describe hov | | | | |
| 1 Neturel 5 Pending investigation | on | injury | | Yes 2□No | | | | | |
| 3 Sulcide 6 Could not determine | be 28e. Placa of Injury building, etc. (5 | - At home, farm, si | reet, factory, office | 9 2 | 28f. Location (Stre City or Town, | et end Numbe Stete) | or or Rural Rout | e Number, | |
| | Dunumg, a.c. (| Opoury) | | | J., J. 10mi, | | | | |
| | Physician: To the best of m | | | | | | | augada) | |
| (Check only 2 Medical Expone) | aminer: On the basis of ex and manner stated | | ivesligation, in my | opinion, death occurre | o al ine time, dal | e end piece, a | na due to the c | ause(s) | |
| 29b. Signature and title of certifier | DIA | 11 ~ 14 | 29c. Licer | nse number | 29 | d. Dete signed | (Month, Day, Y | (ear) | |
| 10/Weg-U. (MO) 5 MJ. 123+24 02/16/2000 | | | | | | | | | |
| 30. Name and address of person wh | o completed cause of deat | th (Item 23a) (Type. | Print) | - | | , 1 | 0, | ^ | |
| DLUSEFTUN | LAWOYII | N.m.D. | 3901 | GreenSD | Sing # | Ve B | altime | EMI), | |
| 31. Date filed (Month, Day, Year) | 32. Registrar's | s Signature | | | | | Velive | 7,10 | |
| FEB 2 2 2000 | Benevy , | 5. do | de | | | | | | |
| 14 - 4460 | | 7 | | | | | | | |
| | | | | | | | | | |



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** FEBRUARY 19 2000 6:28 p.m. Rebbert Nancy /Medical 4a Facility Name (H.obt institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A If Under 1 Year If Under 24 Hrs.
Montha Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB. 2, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Montha 1□M 257F MARYLAND Yrs. 81 Director 215-01-3703 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 1 No Director 268-1 MARYLAND BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Same 23a or 8810 WALTHER BLVD., APT. 2217 21234 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 8 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 / Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE OWN HOME HOMEMAKER altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) is marked of Pages 1 and 2 should be JOSEPHINE DePASQUALE ENRICO MONTE 19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If New 27 is any Injury or other trea DIANE R. MILLHISER (DAUGHTER) 215 W. 78TH STREET, NEW YORK, N.Y. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1
☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER CEM. 2/23/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Buan SCHIMUNEK FUNERAL HOME OF BEL AIR, INC. 610 W. MACPHAIL ROAD, BEL AIR, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 10 hrs disease or condition resulting in death) Severe metabolic acidosis Examiner Due to (or as a consequence of) Examiner Cardionyo path The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Box 68760. Physician/Medical eut. Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Renal failure þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? Respiratory failure peen Coagulo pathy 1 Yea 2 No this certificate 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical axaminer? director. Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes > No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation after death.

Director: A
Jin by the fu death. 1 Yes 2 No 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completely filled in by the 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of curtiling 29d. Date signed (Month, Day, Year)

State Registrar

NITA 31. Date filed (Month, Day, Year) FEB 2 2 2000

Wolfe 600 N 32 Registrer'a Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMUSA

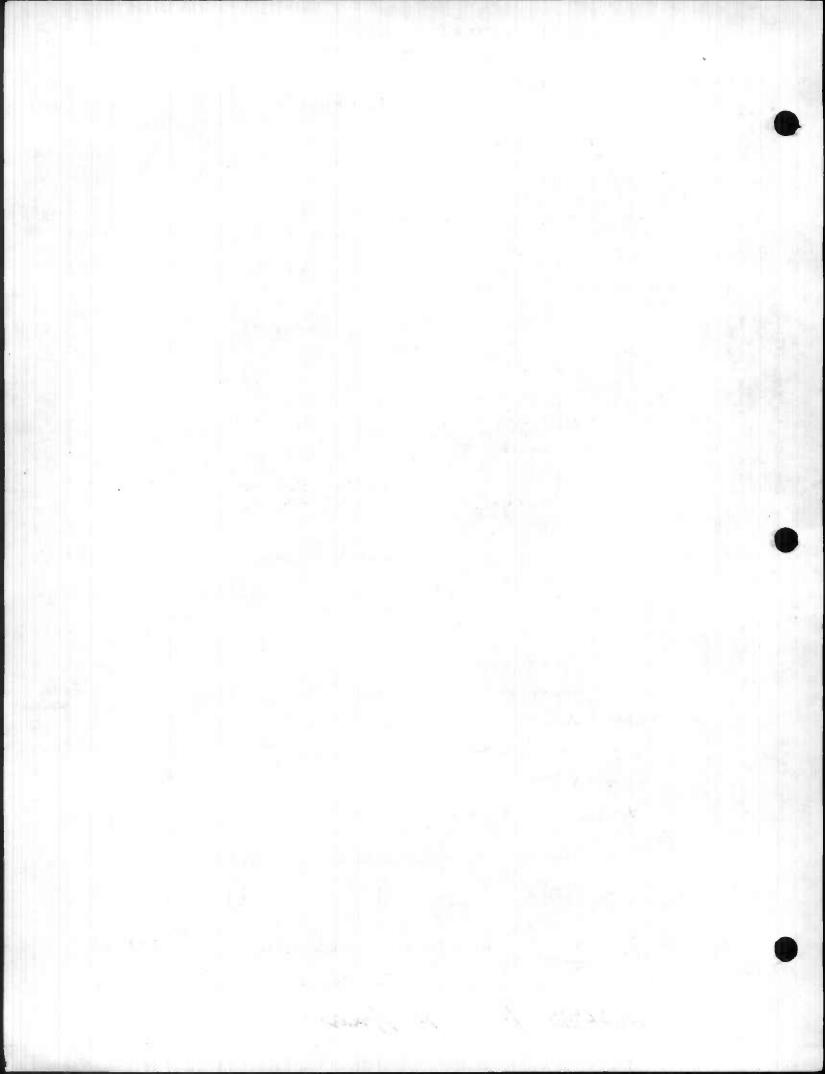
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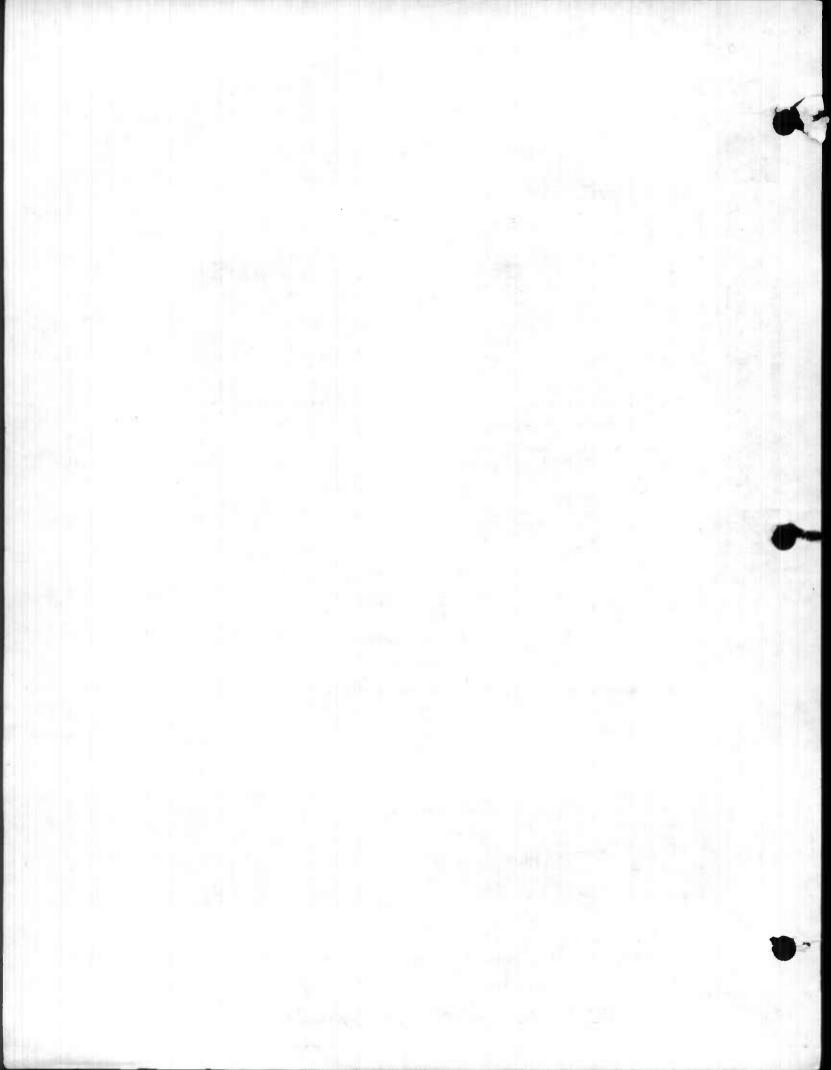
Street

02/19/2000

Baltimore, Manyland



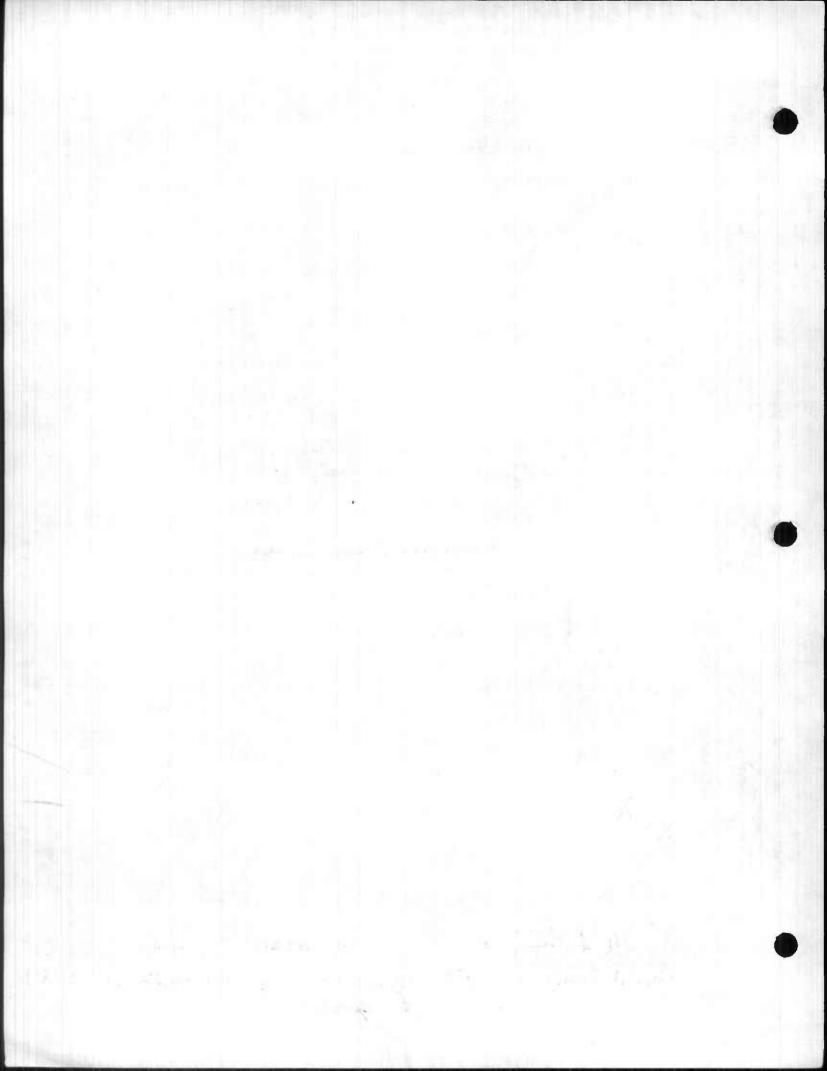
DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death FEB Month 2000 Year **Physician** SEABOLT 20 8:00 am MARY ANN /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 307 Locust Ave, Baltimore Birthplace (State or Foreign Country)
 PA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) July 22 19 7. Aga (In yrs. last birthdey) **Funeral** Days 1 M 2 X F 1930 212-26-7157 Yrs 69 Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at **Baltimore** Essex 1 ☐ Yas 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 307 Locust Ave. 21221 USA Norma 23a death Funeral 12. Was Decedent Evar in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flet any injury or other traumatic event 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dataa: 1 Nevar Merried 25 Merried altimore, Maryland 21215-0020 1 ☐ Yea 2 ☑ No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent'a Usuei Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 8th Murray Inc. Factory Worker 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver A Schotts Viola Grim 2 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Seabolt /husband 307 Locust Ave Baltimore Md. 21221 Nelson 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta Burlal 2 Cramation 3 Removel from State Gardens of Faith Cemetery 2/22/2000 Rossville MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funaral Service Licensee 22. Name and Addrass of Facility Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 23a. Parfl. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or hear failure. List only one ceuse on each line. Approximeta intervel Between Onset end Death **Physician** MATASTATIC BREAGT CENCER immediate Cause (Finei diseasa or condition rasulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician end s the burial-transit The law requires that the death certificate be syscured Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the Due to (or as a consequence of) for use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 3 Probably 4 Unknown 1 Yes 2 No signed b Records, b been significant 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy performed? Completed pege 2 2 No 1 Yes 1 ☐ Yea 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 11 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and placa, and due to the causa(s) and manner as stated.
2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number 1 MD D18320 causa of death (Itam 23a) (Type, Print) 30. Name and address of person who com-7.0. Johns Hopkins ONCOWY CESTER BEHINDER TO 2128 H. Fetting 32. Registrar's Signature 31. Date filed (Month, Day, FEB 12,5 5000 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05478 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHARLOTTE SCHISLER Month Day Year TEBRUARY 18 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALISTOWN BALTIMORE HOSPITAL NORTHWEST | Months | Days | Hours | Min. | Nov. 16, 1929 | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryland | Maryla 5. Social Security Number 7. Age (In yrs. last birthday) Months 10 M 20 F 217-24-1092 70 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Hebbville 1□Yes 2□No 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 2901 North Rolling Road 21244-2019 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th College (1-4or 5+) Public Stenographer Self-Employeed 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Bodlien Alice McCorney 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Norvil F. Schisler (Husband) 2901 N. Rolling Rd. Hebbville, MD 21244-2019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Commeter, Crematory of Other (Specify) | Description 5 | Other (Specify) | Baltimore/Washington Crematory Feb. 21,2000 Laurel, Maryland 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signeture of Funeral Service License allner 8728 Liberty Rd. Randallstown, MD 21133-4784 23e. Pet.7. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Finel disease or condition resulting in death) SEPSIS Due to (or as a consequence of): ENTEROLOCCUS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2ETAo 1 Yes 25. Was case referred to medical examiner? 1 Yes 2 Mo 26. Place of Death (Check only one) Hospital: 1 Ampatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending

1 TYes 2 TNo

37333

MO 21137

y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

FEBRUARY 18, 2000

Physician /Medical

Physician /Medical

Examiner

Funeral

Director

must be notified at

Nems 2

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Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: if item 27 is marked other th jury or other traumatic event, the

Department of Important: If any Injury or

Director

Funeral

by

Completed

the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

Box 68760

P.O.

Division of Vital Records.

Examiner Physician/Medical the ò Completed certificate funeral director, Be this

The law requires that the death certificate be death.

or Attending Physician: edical Certification: To within 24 hours after deat To the Funeral Director: Hospital \$

State

C. PAVI 31. Date filed (Month, Day, Year) Registrar

2□ Accident

3 Sulcide

29e. Certifier (Check only one)

4 Homlcide

29b. Signature and title of certifier

investigation

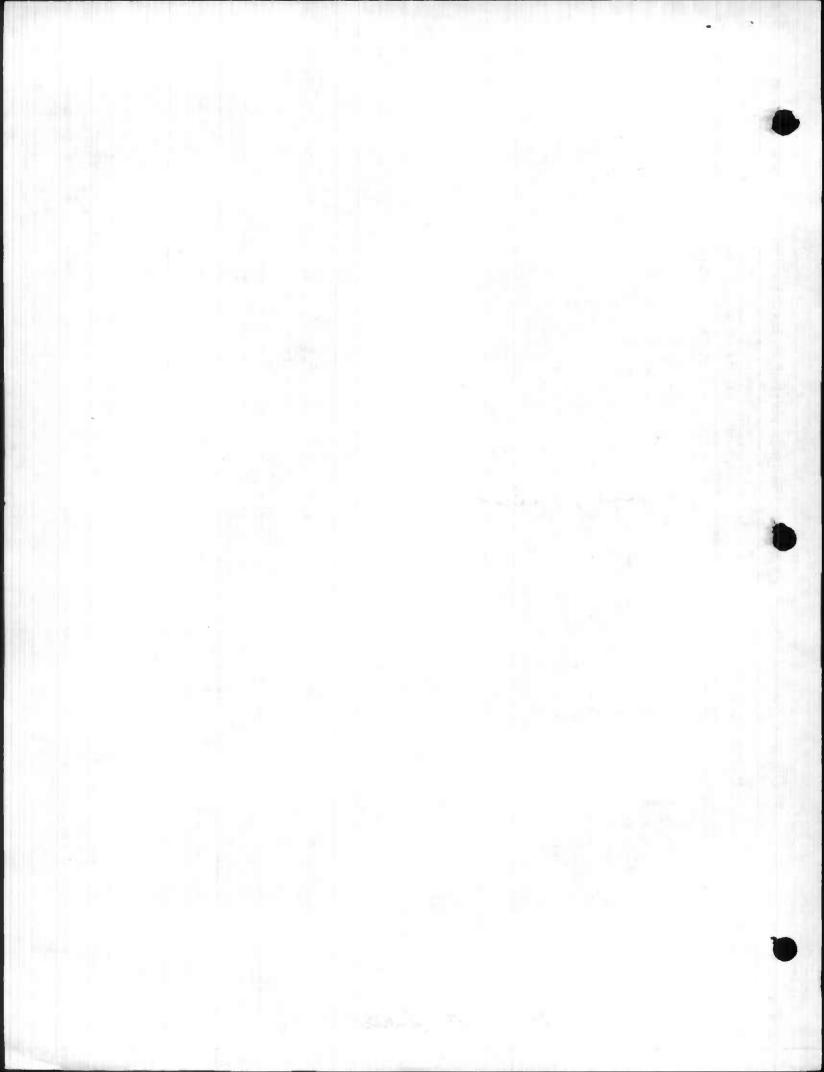
6 Could not be determined

MO,

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

NHC, BALTO. 32. Registrer's Signature 100xxx

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Droots ^{Day}, 2000 FEBRUARY ACION 2:40 AM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Walkersville
If Under 24 Hrs. 8. Date of
Hours Min. (Month, Glade Valley Nursing & Rehab Ctr Frederick If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 M F Days 89 Vrs 220-16-1867 Apr 29, 1910 MD Usual Residence of Decedent 10b. County 10e State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Frederick Knoxsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1331 A Jefferson Pike 21758 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: white 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4 or 5+) none seamstress/cook garment/high school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Harry D. Axline Alma J. Henderson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Snoots/son 1331 A Jefferson Pike Knoxsville, MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph By Van Sant 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) oars Que to (or es a consequence of) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) Part II, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of ertifier 29c. License number 29d, Date signed (Month, Dev. Year)

The law requires that the death certificate be axecuted Box 68760. P.0. Division of Vital Records, or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

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permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified a once.

Physician

Examiner

/Medical

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Physician/Medical Examiner

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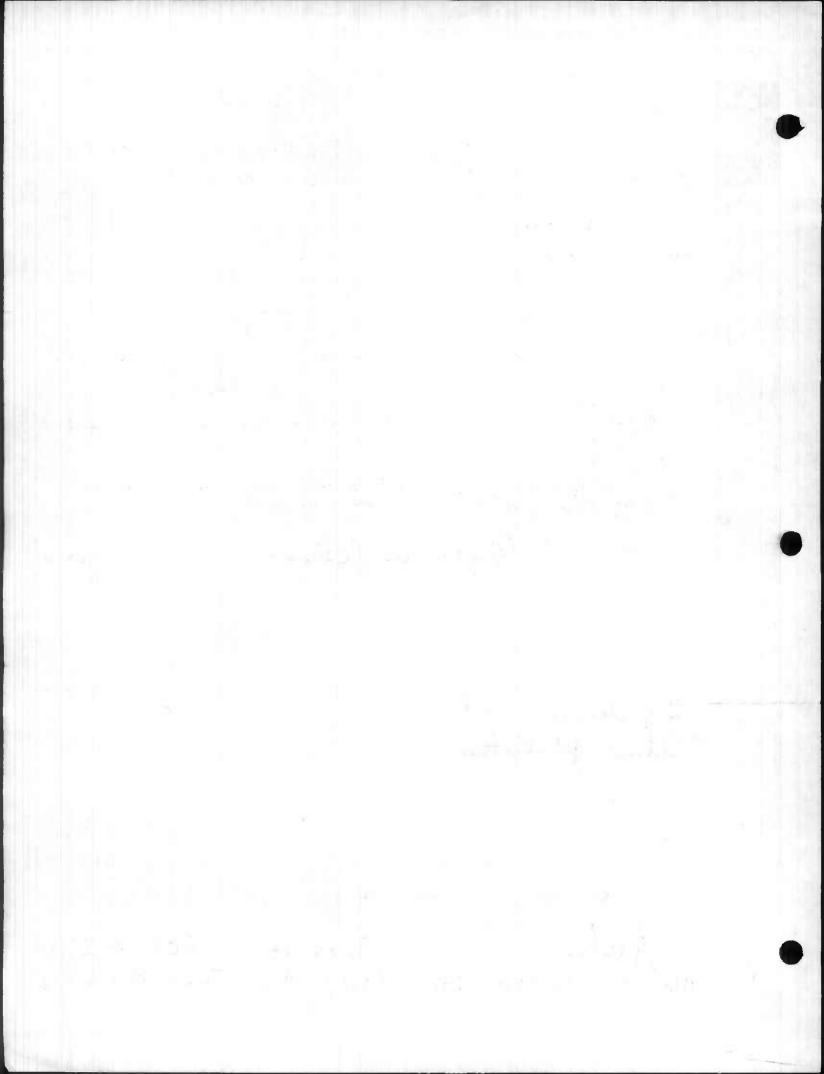
Baltimore, Maryland 21215-0020

State

Dete filed (Month, Day, Registrar

FEB22 2800 32. Registrar's Signature Copera

and address of person who completed cause of death (Item 23e) (Type, Print) MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Physician JAMES SCOTT JANUARY 8, 2000 10:00 PM *⊶7*Medical 4b, City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner St. Thomas Moore Nursing Home Hyattsville Pr If Under 24 Hrs. 8. Date of Birth Hours Min. De(Month Opay, 19933 Prince Georges 9 Birtholece (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 65 Yrs. **Funeral** 1**X**) M 2□ F Months Deys urgkyrown Yrs. Director 224-40-2888 Usual Residence of Deceden 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits unknown un killonena 🗆 No unknown unknown Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? Funeral unknown USA_ 14. Race - American Indian, unknown 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: black by 3 ☐ Widowed 4 🕅 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown home improvements 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 2 unknown unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 sh Department of Heelth and Important: If Item 27 is m eny Injury or other traum pnce. 4922 Lasalle Rd St. Thomas Moore Nursing Home Hyattsville, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state 21. Signature of Euneral Service Licensee Joseph B. Van Sant 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street yst B. Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death · Acoured Immunode from cy Syndrome tmmediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementra þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medicel exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medicat Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier

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the Maryland

death

item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or item

Physician

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Box 68760,

Division of Vital Records,

/Medical Examiner

attending physician end for use es the burial-tran

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Within 2 To the

Hospital 24 hours

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altimore, Maryland 21215-0020

31. Date filed (Month, Day, Year)

32. Registrar's Stonature

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30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

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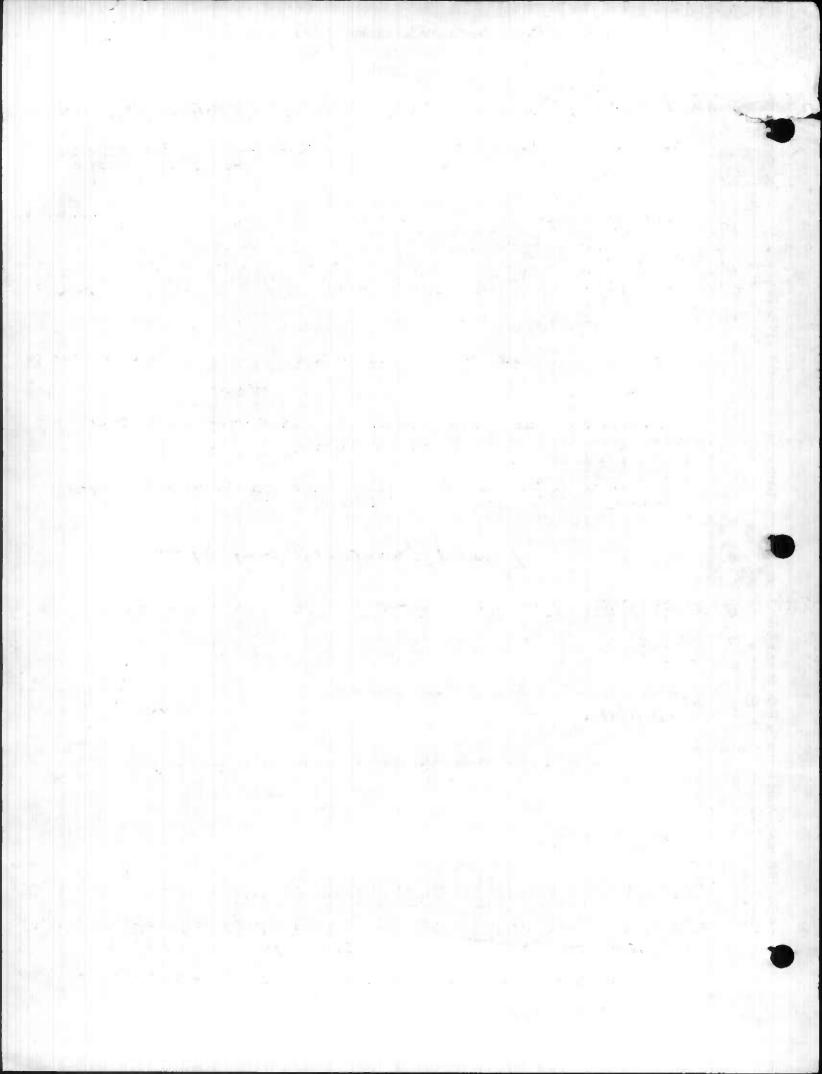
NE # 213

WASHINGTON DC 20017

Registrar

FEB22

ELLING G. BUSTOS



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Jast) 2. Date of Death 3. Tima of Death SMUCK FEBRUARY **Physician** KEX 8:00 pm 19,2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Lorien Nursing Home Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2월 F Yrs. 81 Director May 11, 1918 Maryland 215-10-7648 Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Woodlawn 1 ☐ Yes 2 ☐ No Director 288-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Norra 23a U.S.A. Funeral 1918 Woodlawn Drive 21207

13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Biack, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☑ No Specify: and other than "natural", of event, the Medical Exar Specify: à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Clerical Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked or any Injury or other traumatic eve Conrad Bernhard Mary Louise Schafer 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Frizzell (Son) 5 Glynn Garth, Reisterstown, DM 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a, Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removai from State 2/22/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. nen 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** ALZHEIMERS MSEASE VEARS /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enfer Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): pue physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): signed by the at I be detached for Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 has 1 Yes 2 No certificate 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b Time of 28c. Injury at Work? After 1 Neturai 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number

State Registrar

FEB 2 2 2000

32. Registrar's Signeture

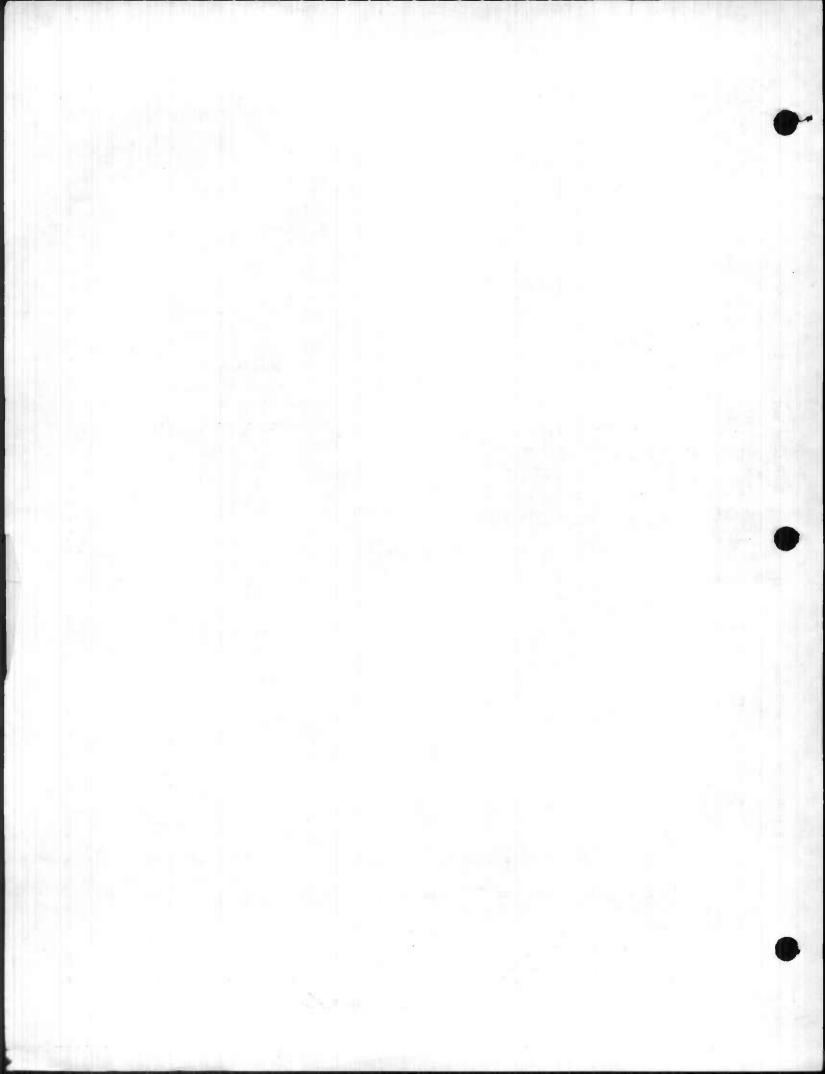
ANAPOLIS RO ELLICOTT CITY MD 21042 9501 OLD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAN RER MO

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31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

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3. Time of Death

Physician

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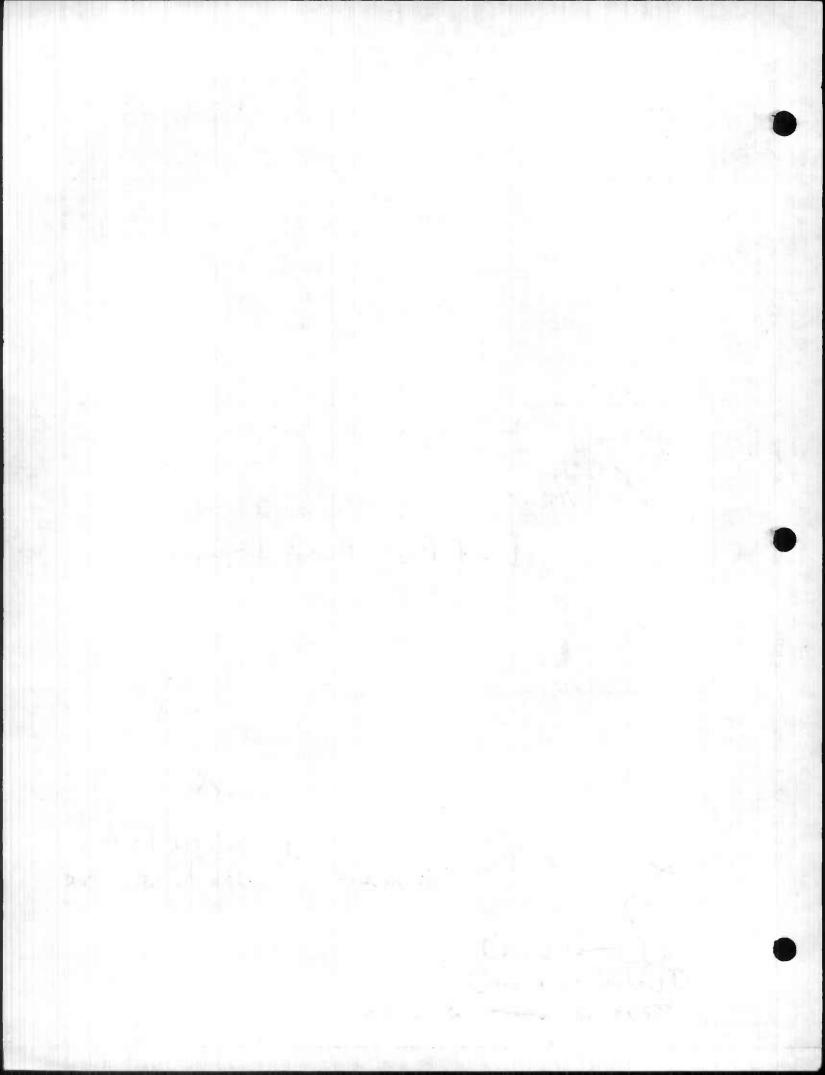
1. Decedent's Name (First, Middle, Last)

Month Year 11,2000 FEBRUARY 5:05P.M. Shahada Sullivan /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY HOSPITAL BALTIMORE ff Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2☑F Yes. Director 220-55--2892 03 21 Usual Residence of Deceden with the Manyland 10s. State itel Hygiene. Id other than "netural", or Itema 23a or 28e-f ahow avant, the Medical Examinat mest be notified at 10c. City, Town or Location 10d. Inside City Limits XX as 2 No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1820 Madison 21217 U.S.A. Ave 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes No If Yes, Give Year or Detes: (Collever Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NA NA NA NA altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) . Pages 1 and 2 should be fill ment of Health end Mentel Hant: If them 27 le marked off jury or other traumatic avan 8 0 Odel Sullivan Verlecia Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aunt 21216 1517 North Bentalou Street, Baltimore Md Valeria Turner Nobles 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State XXBurial 2 Cremetion 3 Removal from State permit. Page Department of Important: If eny Injury or 4 □ Donation 5 □ Other (Specify) King Memorial Park 2-21-00 Randallstown, Md 21. Signature of Foneral Service Licens 22. Name end Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) # P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No signed by the 1 Yes 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 Yes 2 No 2 No certificate Division of Vital 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Certification: To # 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Attec JUDE 28e. Place Attending 1 []Natural 5 Pending Subject death. investigation 1 Yes neuten 2 Accident after deatl 6 ☐ Could not be 3 🗌 Suicide Place of trijury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) A Pureral Dir. 8 1820 Hon adison Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the Hosy within 24 ho To the Fund completely 296. Signy 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. FEBRUARY 12,2000 of person who completed cause of death (Item 23a) (Type, Print) M ocke 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 2 2 2000

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Registrar



| Physician | |
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Funeral Director

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Directo ò must be r than "natural", or lisers 23a the Medical Examiner must I Funeral þ Completed Be

il Hygiene. other than "natural", or item

permit. Pages 1 and 2 abouid be file Department of Neatth and Mental Hy Important: if Item 27 is marked oths any Injury or other traumatic event

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

sician and burial-transit The law requires that the death certificate be executed physician s the burial Box 68760. 980 P.O. Records. page 2 s has certificate Division of Vital or Attending Physician: Certification: To this After

To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely lilled in by the fun edical State Registrar

8

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death HUGH L. SLATER FEBRUARY 16, 2000 11:30 A.M. 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MARINER HEALTH OF GLEN BURNIE ANNE ARUNDEL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1E3 M 2□ F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Days Months Hours 248-01-7467 81 JULY 28, 1918 GEORGÍA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL GLEN BURNIE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1120 CEDARCLIFF DRIVE 21060 UNITED STATES 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Merital Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CH. OF THE NAZERENE MINISTER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) LILLA TABITHA HARRIS DAVID ARTHUR SLATER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 1120 CEDARCLIFF DRIVE, GLEN BURNIE, MD 21060 DOROTHY J. SLATER / WIFE 20a. Method of Diaposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stata FEB. 1 ☐ Blirlat 2 ☐ Cremetion 3 ☐ Removal from Stete GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PK. 2000 4 □ Donetion 5 □ Other (Specify) 21. Signature of Furiery Service Licensee KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Electrolyte Inbolance Immediate Cause (Finel disease or condition resulting in death) weeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed

5 Pending

6 Could not be determined

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29e. Certifier (Check only

4 Homicide

26. Place of Deeth (Check only one)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury st Work? investigetion

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yas 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as atated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dele end place, and due to the cause(s) and manner ateted. 29c. License number

29d. Date signed (Month, Day, Year) FEBRUARY 17, 2000

1 Yas 2 No

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

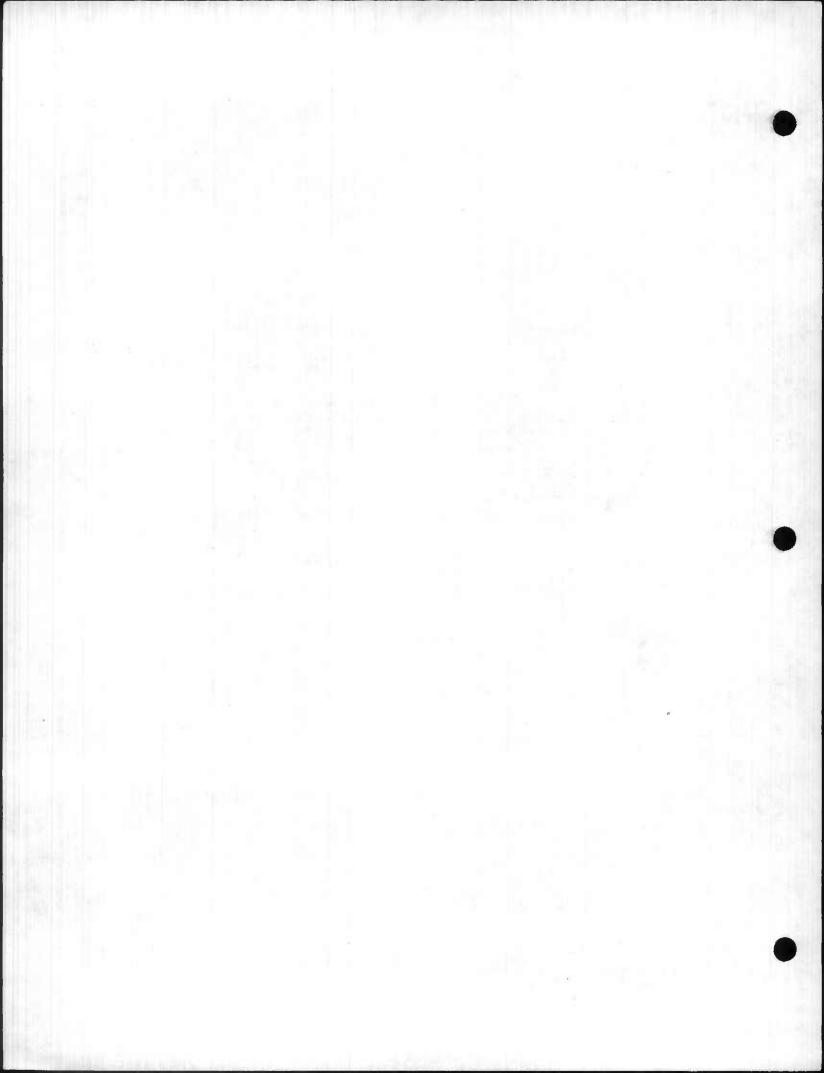
MAHESH O'CHANEY, 7845 OAKWOOD RD, GLEN BURNIE, MARYLAND 21061

2000 32. Registrar's Signature 31. Date filed (Month, Day, Year)

gry

oork

D-40521



Days

10f. Zip Code

Baltimore City

March 18,1916 | Pennsylvania

10g. Citizen of What Country?

February 16, 2000

10d. Inside City Limits

1 XYes 2 □ No

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 7:45 PM Virginia Hanora Stone February 16, 2000 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Haltmore N/A Sinai Hospital of Baltimore If Under 24 Hrs. Hours Min. If Under 1 Ye
Months Da 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

10c. City. Town or Location

1 M 200

N/A

Funeral Director

212-10-2580

10a. Stata

Director

Funeral

þ

Be

Maryland

10e. Street and Number

Usual Residence of Decedent

10b. County

filed within 72 hours efter death with the Maryland ms 23a or r than "natural", or items the Medical Examiner in

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Maryland * nt of Health a if Item 27 is or other tra altimore,

Physician /Medical Examiner

Examiner The law requires that the death certificate be executed buriel-tran pue Physician/Medical the 980 þ Completed page 2 After this certificate has Attanding Physician: director, Be Certification: To funeral

Box 68760 P.O. Records, of Vital Division or Attanding after death. ne Hospital or Attached no 24 hours after detended the Funeral Director pletaly filled in by the Medical zompletaly Within 2

Completed Elmer Schempp 19e. Informant's Neme/Reletionship (Type, Print) 3406 Hayward Avenue Mr. Robert L. Stone/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 73.Ca Can 7922 Wise Ave. Immediate Cause (Finel disease or condition resulting in death) lerminal depiration Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Pert ff. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Obstructive for 25. Was casa referred to medical examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide

TO

32. Registrar'a Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

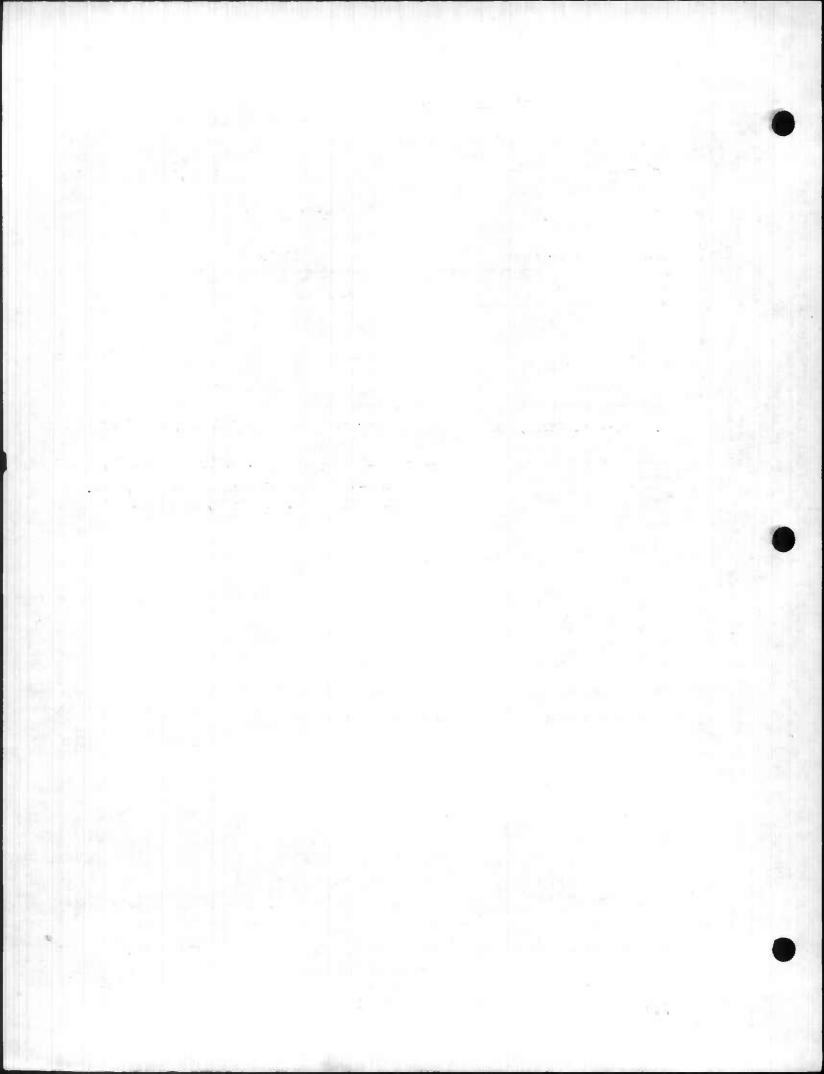
31. Date filed (Month, Day, Year) FEB 2 2 2000

3406 Hayward Avenue 21215 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, atc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Seamstress Sewing Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bertha Pulket 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21215 20c. Location - City or Town, State Date Sacred Heart of Jesus Cem. 2/19/00 Dundalk, Maryland Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirátory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death 12 hours 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar David Kaufman zoto I west Bluedeve trunce, Bultimore, HD 21215

RESCOO



DHMH 16 Rev 6/95

State Registrar

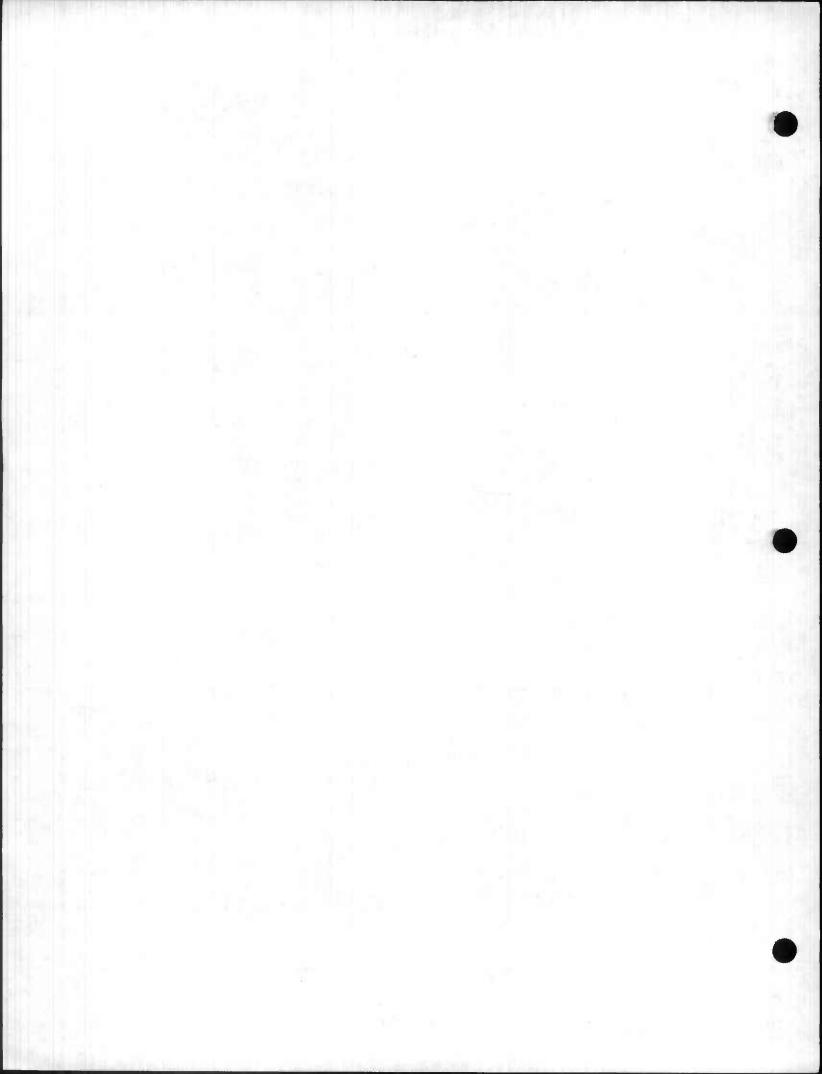
31. Date filed (Month, Dey, Yeer)

FFB 2 2 2000

Holly R. Dahlman, MD; 1838 Greene Tree Rd Ste 306;

32. Registrer's Signeture

Baltimore, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death FEBRUARY Day 18 2000 **Physician** SUGAR 20:18 GOLDON /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE N/A THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT-26 1920 9. Birthplace (State or Foreign Country) SOUTH CAROLINA 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** M 20 F Months Days Hours 79 Yrs. 220-07-0194
Usuel Residence of Decedent Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director BALTIMORE MD BALTIMORE 288-1 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number ò 8201 PUMPKIN SEED COURT 21208 USA Berna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? ☆ Yes 2 □ No WW II H Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or the any Injury or other traumetic event, the Medical Examics 1 Never Merried 2 Merried altimore, Maryland 21215-0020 Specify:WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 DEVELOPER REAL ESTATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be JULIUS SUGAR SARA MILLER 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 8201 PUMPKIN SEED COURT BALTIMORE, MD. 21208 LUCILLE SUGAR/WIFE 20e. Method of Disposition
1 ☐Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta Date 4 ☐ Donation 5 ☐ Other (Specify) FEB. 20/00 BALTIMORE, MD. HEBREW FRIENDSHIP 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Final three days Sepsis disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner one week moummin 2 physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of): 4000 Physician/Medical signed by the a P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has b 1 Yas 2 No Division of Vital al or Attending Physician: T s after death. I Director: After this certificat 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Deeth 28e. Dete of Injury (Month, Dev 28b. Time of 28c. Injury at Work? Certification: 1 Netural 2 Accident 5 Pending Investigation 1 Yes 2 No 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) n 24 hours after ne Funeral Direct nietaly filled in b 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. To the Hosp within 24 hor To the Fune completely fi edicai 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 2000 ES- 000 March 30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print) North JOHNS MENTIN 600 Street

DHMH 16 Rev 6/95

State

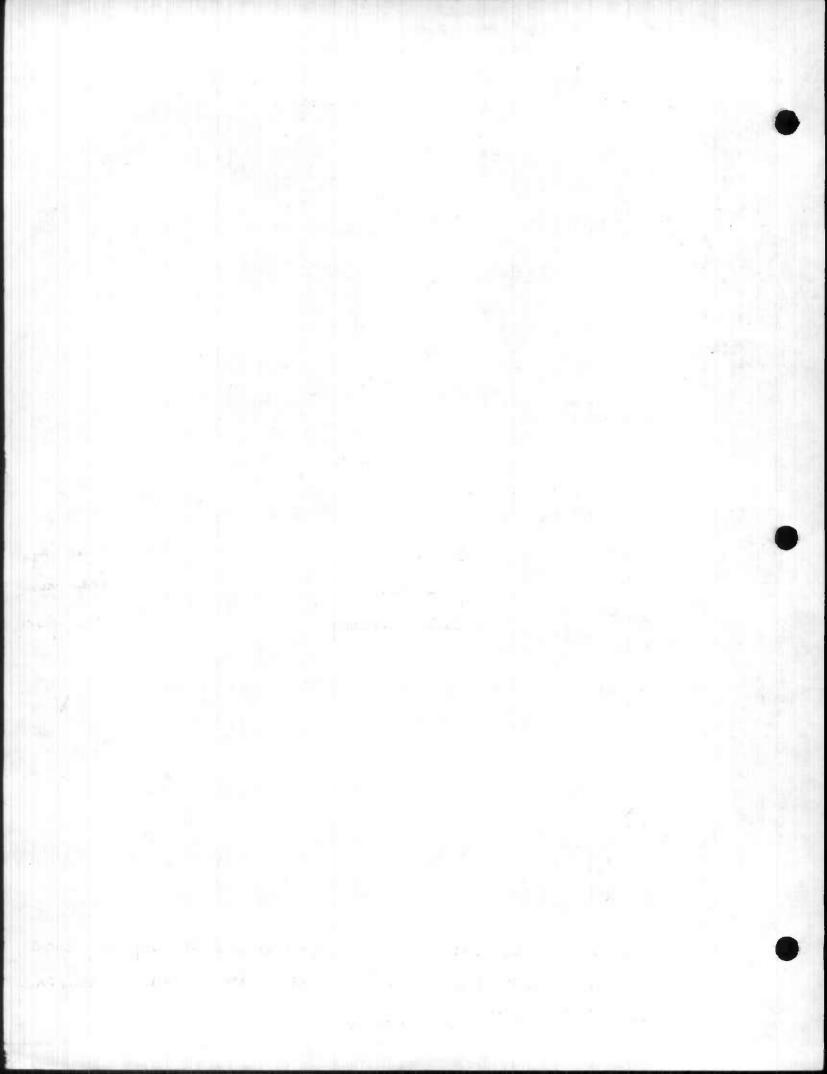
Registrar

31. Date filed (Month, Dey, Year)

FEB 22

2000

32. Registrer's Signature



amend item 1 per phys. Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 05487 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Betty May Scheib Betty Mae Scheib February 10, 2000

4b. City, Town, or Location of Death 4c. County of Death 15:30 /Medical 4a Facility Name (If not institution, give street and number) Examiner Fallston General Hospital Fallston Harford Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 1, 1926 If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2004 Months 212-20-4333 74 Yrs. Director **Usual Residence of Decedent** the Maryland 10a, State 10b. Counts 10c City Town or Location than "natural", or items 23s or 28s-f show the Wadiesi Examiner must be notified at 10d. Inside City Limits Harford Belair 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2205 Byrnes Ct. Apt C 21015 U.S.A. Pages 1 and 2 should be filed within 72 hours after death we nent of Health and Mentel Hyglene.
Int: If Hear 21 is marked other than "natural", or Nema 23s inty or other returnatio event, in "Health Earth man in 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2☐No If Yes, Give Year or Dates: 1 Never Merried 2 Married Saitimore, Maryland 21215-0020 1 Yes 20XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Royston Willie Julia Nancy Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Daniel Scheib/Husband 2205 Byrnes Ct. Apt C Belair, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other p. Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removet from State permit. Page Department of Important: If eny Injury or once. Gardens of FaithCemetery 2/14/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 21. Signature of Funeral Service Licenses 6415 Belair Road Baltimore, Maryland 21206 name, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in. List only one cardiac or esch line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final CONGESTIVE HEART FAILIURE disease or condition resulting in death) Examine Due to (or as a consequence of) Examine DISEASE ORONARY physician and the burial-transit requires that the deeth certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 NEUMONIA Physician/Medical Due to (or as a consequence of) attending p EMPHY SEMA P.O. 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. aigned by the 1 Yaa 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an eutopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Atlanding Physician: within 24 hours after death.

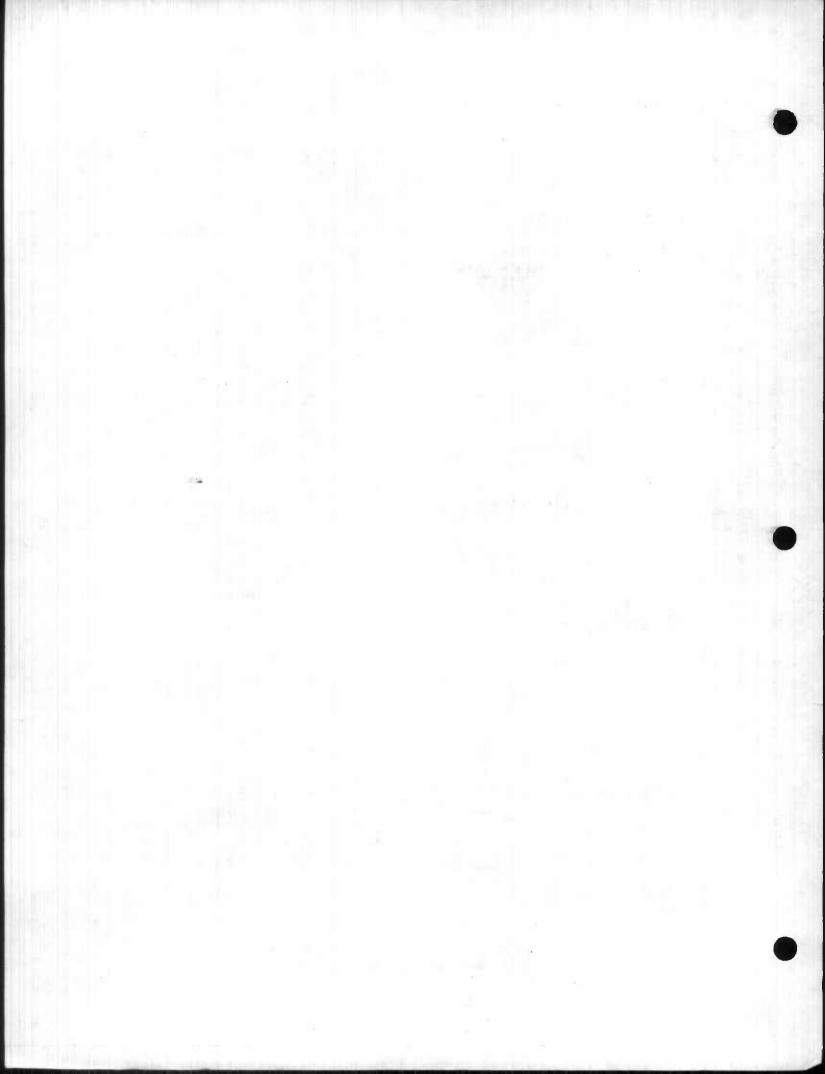
To the Funeral Director: After this certifica completely filled in by the funeral director; p 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1□ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 (PNatural 26a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aller 0459211 SYED F. MAHMOOD M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL 4-C NOKTH AVENUE SUITE 424 AIR MARY LAND 21014 31. Date filed (Month, Day, Year) 32. Registrer's Signature State FEB22 2000 belier Registrar Boarks **DHMH 16 Rev 6/95**

Sample Buch property 100 9 5 5 S A THE LINE TO and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** February 20, 2000 Georgianna Elizabeth Snowden 4:45 am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1115 North Marlyn Avenue Baltimore Essex If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□M 2XF 213 34 3360 Yrs. 66 Director Dec. 4, 1933 Maryland Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itema 23a or 1115 North Marlyn Avenue 21221 USA Funeral death 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Nem 27 Is marked other than "natural", or Nan any Injury or other traumatic event, the Health Examples 1 Yes 2 XNo
If Yes, Give
Yeer or Detes: 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Inspector Clothing Mfg. 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Henry Snyder Catherine Ruth 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lawrence Snowden (Husband) 1115 North Marlyn Avenue Baltimore, Md. 21221 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete Date 20a, Method of Disposition cemetery, crematory or other place) 1⊠ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete Holly Hill Mem. Gardens 2/23/2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Neme and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, fair . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Causa (Finel -una disease or condition resulting in deeth) Cancer Examiner Due to (or as a consequence of): Examiner the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. physician Physician/Medical Due to (or es a consequence of): the 5 950 P.0. Pert il. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Emphesena Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu page 2 s 1 ☐ Yes 2 □XNo 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yas 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After or Attending 1 Neturei 5 Pending hours after deeth, uneral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 ☐ Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by edical 29e. Certifie 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 00 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Suite 14 Baltimore, MD Kinzuger MD 1576 Merritt Blud 21222 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State FEB 2 2 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Christina Marie Severn February 20,2000 3:40 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1100 Middleborough Rd. Essex Baltimore 8. Date of Birth (Month, Dev. Year) March 28, 1966 Maryland 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 XF Days Hours Min 212 76 9324 Yrs. 33 Director Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28s-4 show notified at ahow Maryland Baltimore 1 ☐ Yes 2 1 No ESSEX Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? or hams 23a or the Medical Examiner must be 1100 Middleborough Rd. 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Nevar Married 2 🔀 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ②No Specify: Specify: White A 3 ☐ Widowed 4 ☐ Divorced Completed illed within 72 ho Hygiene. other then "netu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper coemit. Pages 1 and 2 should be flied w Department of Health and Mental Hygien Important: If them 27 is marked other th. Accounting Firm 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Karol Edward Zepp Patricia Agnes Varth 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Severn (Husband) 1100 Middleborough Rd. Baltimore, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Oak Lawn Cemetery 2/23/2000 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Md. Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart feilure. List only one cause on each line. Approximate Interval Betwo Onset and Death **Physician** /Medical Immediate Cause (Final OVARIAN CANCER disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 1 Yes 2 No 3 Probably 4 Unknown signed bed be Records. p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peeu page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Patter death.

Director: After 1 After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide e Hospital o 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) To To William P. N. Sino 2-21-80 71680 30. Name and address of person who completed cause of death (Item_23a) (Type, Print) 301 St. PAUL PL.

State Registrar

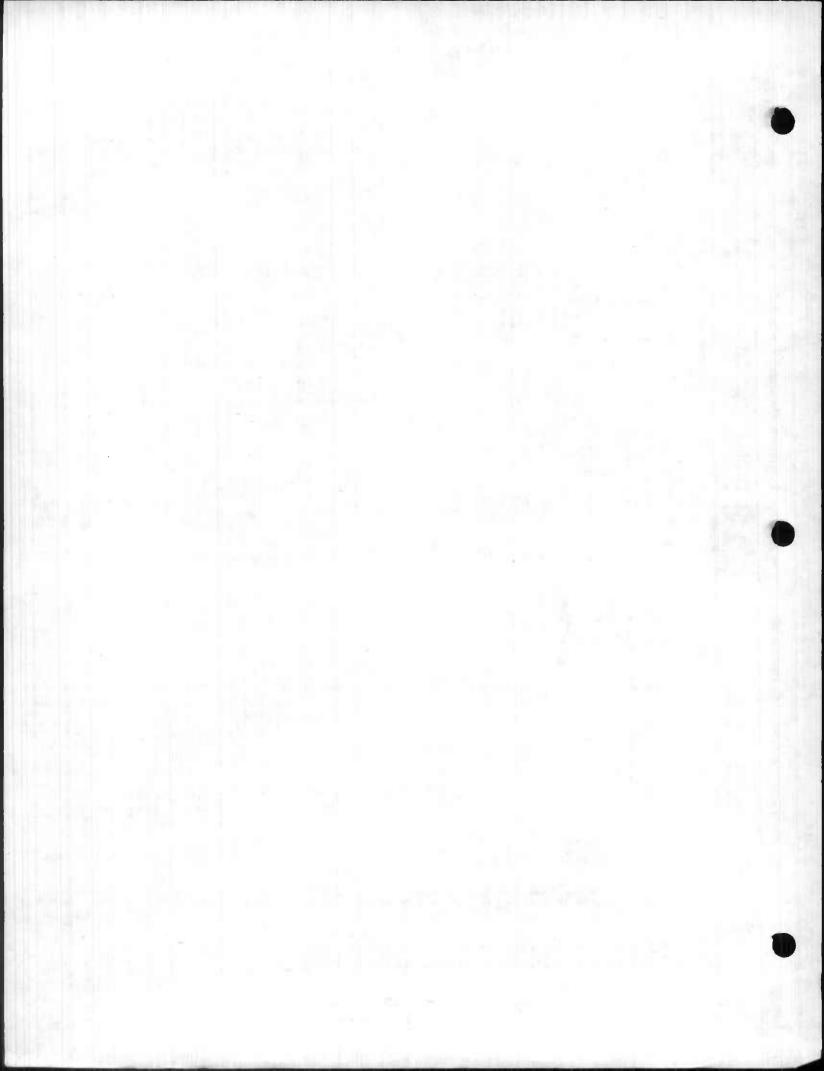
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31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

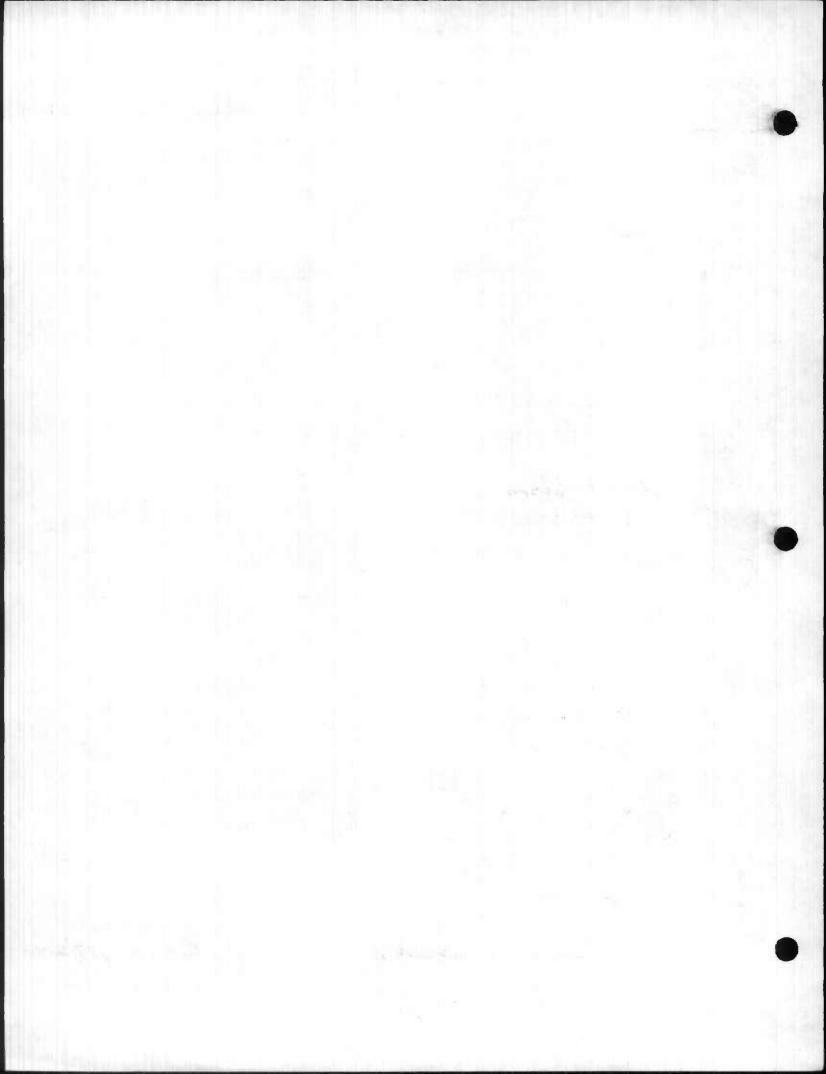
32. Register's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Menth

| | 1. Decedent's Name (First, Middle, La | 151) | 08 | rtificate of | Death | 2. Date of De | Reg. No. ath | 3. Th | ne of Deeth | | |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------|--------------------------------------------|--------------------------------------------------------|-----------------------------------------|------------------------------------|----------------------------------------|----------------------|--|--|
| hysician | MILDRED JOS | T TVCON | | | _ | Month | Day | Year | | | |
| /Medical | 4a Fecility Name (If not institution, give | | | | 4b. City, Town, or | Location of Death | 17 2 4c. County | | 25 AM | | |
| xaminer | Saint Joseph | | enter | | Tows | | | altimo | 0.0 | | |
| | | | n yrs. last birthday) | If Under 1 Year | | | | | | | |
| neral ector | | 1□M 2XF | 87 Yrs. | Months Days | Hours Min. | 8. Date of Bir (Month, De June 2 | y. Year) 5, 1912 | 9. Birthplace (S Country) Maryla | | | |
| B == | 10a. Stete 10b. County | 10 | C. City, Town or Lo | ocation | 77 | | | 10d. Insi | de City Limits | | |
| notified at frector | Maryland Baltimon | co Country | Cockey | | | | | 10 | Yes 2 No | | |
| in Die | 10e. Street and Number | e County | Cockey | 10f. Zip Code | | | 10g. Citizen of V | What Country? | | | |
| uat be | 13801 York Road | | | , | 1000 | | | | | | |
| ner must be funeral Di | 11. Marital Stetus | 12. Was Decedent Eve | rin U.S. 13 | | LO30 Hispanic Origin? (S | necify Yes or No | US 14 Bac | A - Amarican India | nn . | | |
| by Funeral Director | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: | | If Yes, specify Cub 1 ☐ Yes 2 ☑ No | Hispanic Origin? (S pan, Mexicen, Puerl Specify: | o Rican, etc.) | Specify | ck, White, etc. | | | |
| | 15. Decedent's E | | 16a, Dece | dent's Usuat Occu | pation | | 16b. Kind of Bu | usiness/Industry | | | |
| Completed | (Specify only highest gra | ade completed) | (Give | kind of work done DO NOT use retire | during most of wor | rking | | | | | |
| E | Elementary/Secondary (0-12) | College (1-4or 5+) 4 Vrs | Bool | kkeeper | | | Educa | e School | | | |
| | 17. Father's Name (First, Middle, Last | | 10001 | посред | 18. Mother's Nar | me (First, Middle, | | | | | |
| To Be | John Carl Jost | | | | Comb | u d o | 0 | 1 * . | | | |
| F | 19a. Informant's Name/Relationship (| Type, Print) | 19h Meili | no Address (Stree | Gertr | | | hmier Stete, Zip Code) | | | |
| | | | | | | | | | | | |
| | Frederick C. Tyso 20a. Method of Disposition | on, Jr. (So | 206. Place of Dispo | 09 Bladon osition (Name of | , | noenix, | Maryland 20c. Location - | d 21131 City or Town, Sta | te | | |
| | 1 Burial 2 Tremation 3 | Trientovanioni State | | | | | | | | | |
| | 4 Donetion 5 Other (Special | | | unt Crema | | 2/19/00 | Baltimo | re, Mary | land | | |
| | 21. Signature of Furueral Section Liqui | | 1 | 2. Name and Addre | Mindofol | Hunara | 1 Homo | Tnc | | | |
| | Martin D. Car | rson | | 500 Vorb | MIEGETET(| altimoro | Marvil. | and 2121 | 2 | | |
| | 23a. Part1. Enter the disease, or com | plications that ceused the | death. Do not en | ter the mode of dyi | ing, such as cerdia | or respiretory a | riest, | Appro | kimate il Between | | |
| 1 | Martin D. 1980 1 6500 York Road, Baltimore Maryland 21212 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart faiture. List only one ceuse on each line. Approximate Interval Between Onset and Death | | | | | | | | | | |
| | Immediata Cause (Final disease or condition | ISCHEMIC | | | ONE | E WEEK | | | | | |
| | resulting in death) | a | e to (or es a conse | - | | | | | | | |
| ě | | | | | | | | | | | |
| Examiner | Sequentially list conditions | b. — Due | e to (or as a consec | quence of): | | | | | | | |
| | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | 1 | | | |
| Cal | that initiated events | C | to (or as a consec | quence of): | | | | 1 | | | |
| ledical | resulting in death) Last | 500 | (| 4-2 2.1. | | | | | | | |
| 3 | | d | | | | | | | | | |
| Cla | Post II Other classificant and the | and albustines as a second | a | | landa Grand | ant =: 1 | lahaara | naulhud - d - da : | | | |
| Physician/M | Pert II. Other significant conditions of | contributing to death but n | ot resulting in the u | inderlying ceuse gi | ven in Part I. | | | ntribule to the ca | | | |
| | GASTROINTESTINA | L BLEEDING | | | | 10 | Yee 2 No | 3 Probably | 4 Unknown | | |
| d by | | | | | | 240 14/0- | an autones | 24b. Ware auto | nosy tindings | | |
| Completed | ACUTE RENAL FAI | LURE | | | | 24a. Was perfo | an autopsy rmed? | available i | | | |
| npidu | | | | | | | | of death? | | | |
| Co | | | | | | 10 | Yes 2 No | 1 🗆 Yes | 20XNo | | |
| Be (| 25. Was cese referred to medicet examiner? | | | | 26. Place of De | ath (Check only o | one) | | | | |
| To | 1 ☐ Yes 2 No | Hospital: | 2 ER/Outpatie | nt 3 DOA Ot | her: 4 Nursing H | lome 5 Resid | dence 6 Oth | er (Specify) | | | |
| | 27. Menner of Death | 28a. Date of Injury (Month, Dey Ye | 28b. Time o | af 28c. Inju | | , | now injury occur | | | | |
| atio | 1 Naturel 5 Pending 2 Accident investigation | | ear) Injury | | Yes 2 □ No | | | | | | |
| Certification: | 3 ☐ Suicide 6 ☐ Could not b | 286. Place of Injury | At home, farm, st | reet, factory, office | | | | per or Rural Route | Number, | | |
| ert | 4 Homicide | building, etc. (5 | Specify) | | | City or To | vn, State) | | | | |
| edical C | 29a. Certifier (Check only one) Certifying Ph | yelclan: To the best of miner: On the basis of exa | amination and/or in | h occurred at the ti vestigation, in my | ime, date end plece opinion, death occu | e, end due to the arred at the time, | cause(s) and ma date and plece, | anner as stated. end due to the ca | use(s) | | |
| M | 29b. Signature and title of certifier | 2.12011101 310100 | • | 29c. Licen | se number | | 29d. Date signe | d (Month, Day, Ye | ear) | | |
| | 1 t. | PA | | | | | B 1 | | 1. 2.11 | | |
| | Dealing | - Nus | you M | . D D1649 | 92 | ٥ | Gellen | dry 17 | 2000 | | |
| | 30. Name end address of person who | completed ceuse of deal | (Item 23a) (Type, | Print) | | | | / | | | |
| | BEATRIZ P. DIZ | | 7601 05 | SLER DR | IVE, TO | SON, M | ARYLAN | D 218 | 204 | | |
| State | 31. Dete filed (Month, Dey, Year) | nnn 32. Registrar's | Signature & | Ance | 1.1 | | | | | | |
| | | | | | | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Deeth Day THA XTON Month Yeer 1045 ELIZA BETH FEB RUARY 2000 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SECOUPS HOSPITAL BALTIMORE BON NA If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 10M 2F Days 213.20.6025 Usual Rasidance of Decedant 10a. Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No NIA mo BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? STREET 2900 WINCHESTER 21216 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No if Yas, Giva Yaar or Datas: 11. Maritai Status 13. Wes Dacedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian Black, White, atc. 1 Naver Merried 2 Married 1 Yas 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highest greda complated) Elamentery/Secondary (0-12) Coilage (1-4or 5+) SALES YRS KETAIL 12 TH GRADE LERK 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Melden Sumema) KOBERT BARKSDALE **IENNESSEE** 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) ST. 2900 WINCHESTER BALTO. THAXTON NON MD. 20b. Place of Disposition (Nema of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) MT. ZION CEMETERY 2.23.00 BALTIMORE 21. Signature of Funeral Service Licensaa 22. Nama end Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MO. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on sech line. Approximeta intarvai Batween Onset and Death immediete Causa (Finel SEPTICEMIA disaase or condition rasulting in daath) DEWBITT Sequentially ilst conditions, if any, laeding to immediate causa. Entar Undarlying Causa (Diseesa or injury that initieted events rasulting in daeth) Last Due to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown DEMENTIA 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of daath? 1 ☐ Yas 2 ☐ No 1 TYas 2 100

Physician /Medicai Examiner

Physician

Examiner

Funeral

Director

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It: If item 27 is marked other
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Department of important: If eny injury or

Pages 1 and 2 should be

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21215-0020

altimore, Maryland

/Medical

and signed by this certificeta if or Attending Physician: after death. Director: After this certifice filled in by the funeral

Physician/Medicai

þ

Completed

Be

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Certification:

Medical

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHIEMERS

25. Was case rafarred to medical axaminar? 1 Yes 2 No

27. Mannar of Death 5 Pending investigation 1 Maturai 2 Accidant

3 Suicida 4 | Homicide

6 Could not be datarmined

28a. Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify)

Date of injury (Month, Day Year) 28b. Tima of

1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28c. injury et Work? 1 ☐ Yas 2 ☐ No

HOSPITAL

26. Pieca of Daath (Check only one)

Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, daath occurred at tha time, deta and place, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion and/or investigetion, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and menner stated. 29b. Signetura end titla of certifier

29a. Certifian

29c. License number 030272 29d. Dete signed (Month, Day, Year)

BACTIMORE,

mo

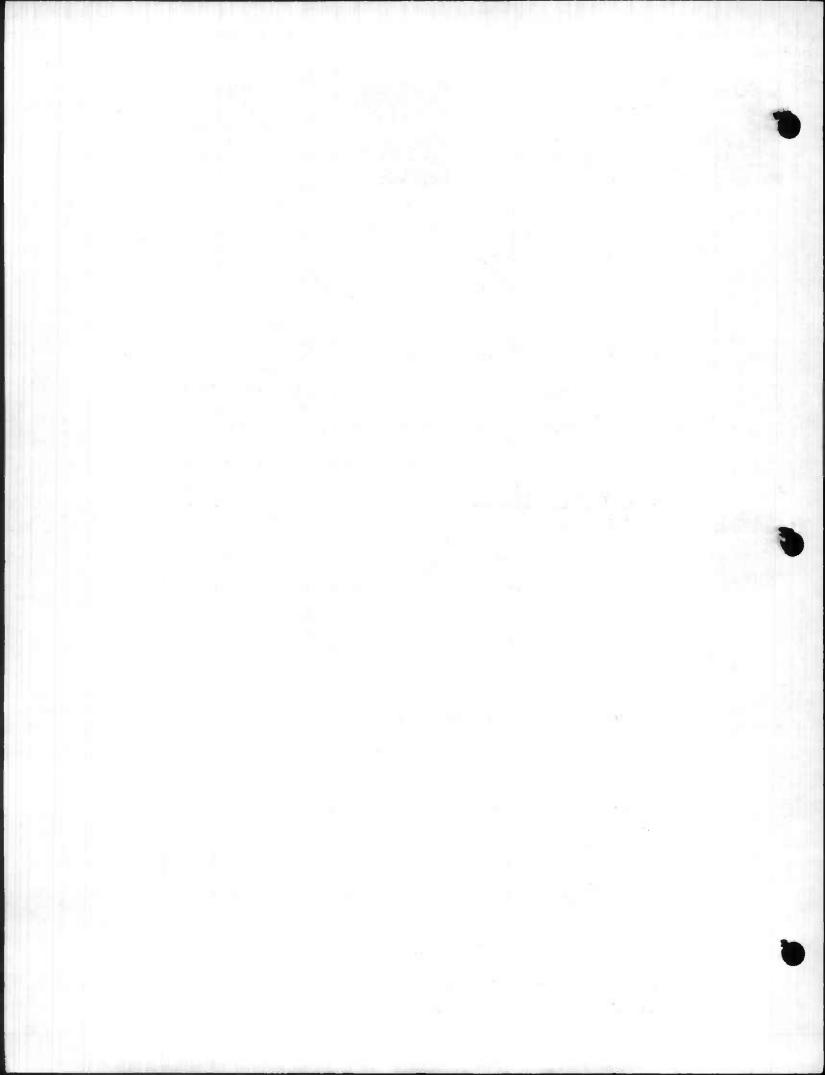
30. Nema and addrass of person who complated causa of death (Item 23e) (Type, Print) MILLER BON SERBURS

31. Deta filed (Month, Day, FEB 2 2

2. Registrar's Signature

State Registrar

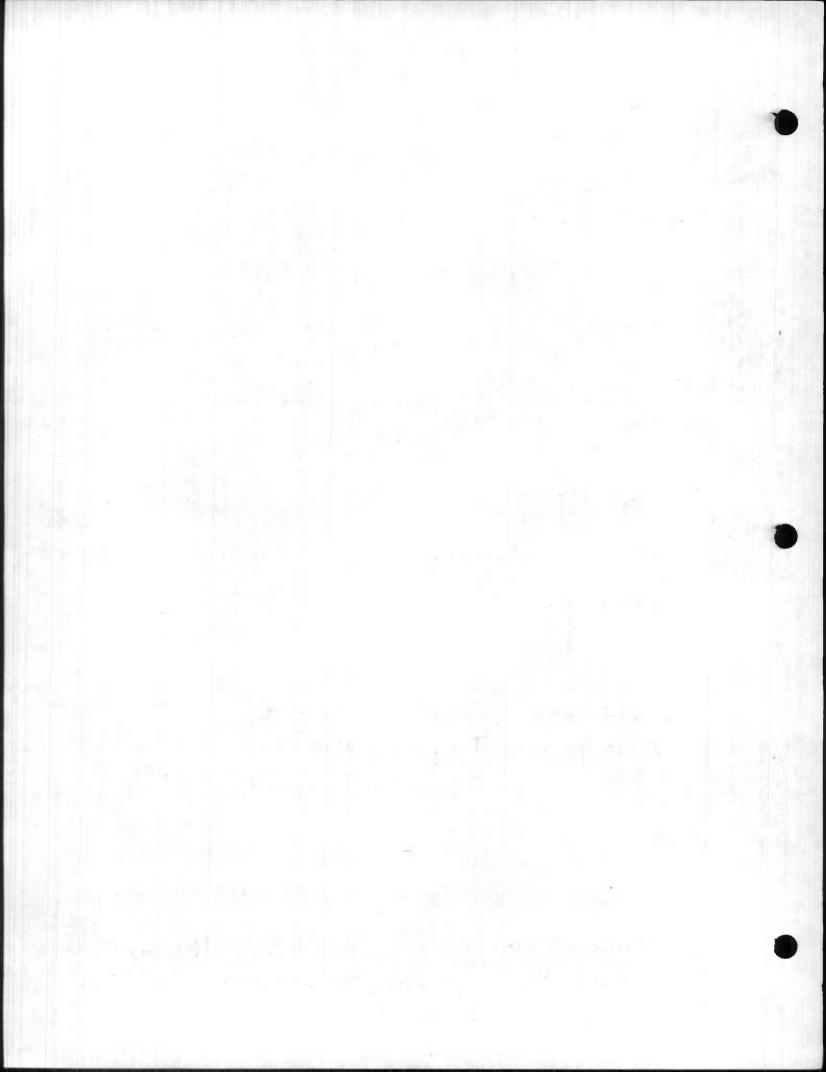
To the Hospital of within 24 hours at To the Funeral D completely filled I



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

| | | • | Cei | tificate of | Death | , | Reg. No. | 0 05492 | | |
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| Ohypinian | 1. Decedent's Name (First, Middle, La: | al) | | | | 2. Date of De | | 3. Time of Deeth | | |
| Physician /Medical | Elisabeth May | | ebruar | y 17, 20 | 11:30 A.M | | | | | |
| Examiner | 4a Facility Neme (If not institution, give | street and number) | | | 4b. City, Town, or L. | | , | | | |
| MILL L | 296 Oak Manor Dr: | Lve | | | Glen Burn | ie | Anne | Arundel | | |
| Funeral Director | 210 00 0101 | ex | | If Under 1 Year Months Days | | 8. Dete of Bin (Month, Da Nov. 1 | Dete of Birth (Month, Day, Year) 10 v . 17 , 1917 Bell of Birth (State or Foreign Country) Maryland | | | |
| 2 | Usuel Rasidence of Decedent 10a. State 10b. County | 10c Ci | ty, Town or Lo | cation | | | | 10d. Inside City Limits | | |
| A market | | Arundel | | Burnie | | | | 1 ☐ Yes 🏋 🖾 No | | |
| or 28e-t i be notified Directo | Maryland Anne I | Arunder | Gren | 10f. Zip Code | | | 10g. Citizen of V | **** | | |
| | 296 Oak Manor Di | | | 21061 | | | United | States | | |
| - 1 25 5 | 11. Marital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | Wes Decedent of f Yes, specify Cult I ☐ Yes 2 ☐ No | Hispanic Origin? (Sp ban, Mexican, Puerto Specify: | pecify Yes or No Rican, etc.) | - 14. Race Bled Specify | e - American Indian, ck, White, etc. "White | | |
| Maryland 21215-0020 d2 shours at an and Mental Hyghen "setural", or treumatic event, the Medical Exam To Be Completed by F | 15. Decedent's Ed (Specify only highest gra Elementery/Secondary (0-12) | | 16a. Deced (Give life. I Super | | pation during most of work ad) | king | Civil S | Service Government | | |
| C President | 17. Fathar's Nema (First, Middle, Last) | | Jupor | | 18. Mother's Nem | e (First Middle | Meiden Sumem | (a) | | |
| and the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first state of the first | Arthur Lawrence B | | | | Mamie G | | | 9) | | |
| Tyla d Men marks marks To | | | 101-11-70 | - Add (0 | | | | Charles Tie Condail | | |
| Ma d 22 st treet | John Richard Thom | | | | er Dr., G1 | | | | | |
| | 20a. Method of Disposition | | | sition (Nama of | | | | City or Town, Slate | | |
| Pages on the fifth | 1 Burjal 2 Cremetion 3 4 Dometion 5 Other (Specific | Removel from State | cemetary, cren | en Mem. | | Peb. 21 2000 | | rnie , Maryland | | |
| Baltimore, | 21. Signeture of Fune at Service Upensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Ho | | | | | | | lome P.A. | | |
| - 40240 | 23a. Part1. Enter the disease, or compshock, or heart failure. List only | Jah. | 42 | 1 Crain | Hwv. S.E. | Glen B | urnie, M | MD 21061 | | |
| 68760, lificate be executed expected as the burial-transit fedical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequ | uence of): | | | | zweeks | | |
| | | d | | | | | | | | |
| death ce death ce at for use | Pert II. Other significant conditions of | entributing to death but not res | ulting in the ur | nderiving cause o | iven in Part I. | 23b. Did | lobacco use cor | ntribute to the cause of death? | | |
| ords, P.O. Box requires that the death certified as signed by the attending hould be detached for use atted by Physician/M | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | | | | abetes | 10 | Yes 2 110 | 3 Probably 4 Unknown | | |
| aw requir | Non Finsul | merTx | pe | Dem. | entig | 24a. Was perfo | an eutopsy med? | 24b. Were autopsy findings available prior to completion of cause of death? | | |
| | | | | | | 10 | Yes 2004N6 | 1 Yes 2 No | | |
| of Vital Re Physician: The is this certificate har and director, page | 25. Was case referred to medical examiner? | Hospitel: | | 100 | 26. Place of Deat | th (Check only o | one) | | | |
| hysic al dire | 1 ☐ Yes ¾⊠ No | 1 ⊔ Inpatient 2 L | ER/Outpatien | 1 3LI DOA | | | dence 6 □Oth | | | |
| Attending Partending Partending Py the funering Militarion: | 27. Manner of Death 1 Metural 5 Pending 2 Accident investigation | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | M 1 | ork? ☐ Yes 2 ☐ No | 28d. Describe how injury occurred | | | | |
| 2 9 # F | 3 Suicide 6 Could not be 4 Homicide determined | building, atc. (Special | (y) | | | City or To | vn, State) | er or Rural Route Number, | | |
| he Hospital in 24 hours he Funeral pletely lilled edical Co | 29e. Cartifier 1 Certifying Phyone) 2 Medical Exam | reiclan: To the best of my known iner: On the basis of axamina and manner stated. | owledge, death ition and/or inv | occurred at the trestigation, in my | ima, data and place, opinion, deeth occur | and dua to tha red at the time, | cause(s) and ma data and place, a | nnar as stated, and due to tha cause(s) | | |
| To the within 2 To the comple | 29b. Signeture and title of certifier | Carte | RD | 29c. Licen | 1459 | | 29d. Dete signed Februar | d (Month, Dey, Year) | | |
| 8 | 30. Name and address of parson who of | Highway | Gle | 0 | rnie,1 | Mar | x land | 21061 | | |
| State | 31. Date filed (Month, Day, Year) | 32) Registrar's signe | eture | , 7 | | U | | | | |

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) **Physician** Samuel J. Varano /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral M 2DF 183-12-5300 Director Usual Residence of Decedant 10e. State 10b. County show Baltimore 10e Street and Number

ear or Detas

Coilege (1-4or 5+)

| s. last birthday) | If Under 1 Year | | If Under 24 Hrs. | | 8. Date of Birth | 9. Birthplace (State or Fore | | |
|-------------------|-----------------|------|------------------|------|---------------------------------------------------------|------------------------------|--------------------------------------|--|
| 9 Yrs. | Months | Days | Hours | Min. | 8. Date of Birth (Manth, Day, Year) March 17,1971 | Co | taly | |
| Perr | | la | U | | | | 10d. Inside City Limits 1 ☐ Yes 2 No | |
| | 10f. Zip | Code | - 3 | (| 10g. Citizen of | What Co | untry? | |

Towson

2. Data of Death

Manorfield Rd. 12. Wes Decedent Ever in U.S. Armed Forcas?
1 Deas 2 Do No Hyas, Giva Year or Detas: 11 Merital Status 1 Nevar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondery (0-12) 17. Fathar's Nama (First, Middle, Last)

1 □ Yes 20KNo Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Circuit Court

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

16b. Kind of Business/Industry Stateof maryland 18. Mother's Nama (First, Middle, Maiden Surname)

White

14. Race - American Indian, Black, White, atc.

Month Day Year February 19,2000 10:26am

Baltimore

4c. County of Death

3. Time of Death

Varano Kalph 19a. Informant's Name/Raiationship (Type, Print)

trancesca Lintini 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2(236 Rd. Pery Hallimo Date 20c. Location - City or Town, Stata 8638 Manorfield

auline Varano-20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 22 vans Ferreral Chapel-Bel Air Forrest Hill, MD 2000

21. Signetura of Funaral Sarvice Licensee the 20 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Nama and Addrass of Facility Evans Chaper of memores 8800 Harford Rd. Baltimire, mD Approximata Interval Between Onset and Death

Physician /Medical Examiner

Completed by Physician/Medical

Certification: To

Medical

6

s 1 and 2 should be filed within 7; of Health and Mental Hygiene.

Baltimore, Maryland

rano

If item 27 is marked other or other traumatic event, it

Completed

Be

000

vonany avery Dua to (or as a consequence of)

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disaase or Injury that initiated avents rasulting in death) Last

Immedieta Ceusa (Final

diseese or condition resulting in death)

| Part II. Other aignificant | conditiona contributing to death | but not resulting In | tha underlying causa | given in Part I. |
|----------------------------|----------------------------------|----------------------|----------------------|------------------|

23b. Did lobacco use contribute to the cause of death?

umbilical hemia, abdominal

1 Yes 2 No 3 Probably 4 Unknown

disease 419

24a. Was an autopsy performed? 1 Yas 2 No

24b. Wera autopsy findings available prior to completion of cause of death? 1 Yas 2 No

5 x 09 3

25. Was case rafarred to medical axaminer?

1 Yas 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

27. Mannar of Death Netural 5 Pending Invastigation 2 Accident 3 Suicida 6 Could not be

28e. Data of Injury (Month, Day Year) 28a. Place of Injury - At home, ferm, etreet, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

29a. Certifier (Check only one)

4 ☐ Homicide

12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated.

29b. Signeture and titla of certifier

29c. License number 020688 29d. Data signed (Month, Day, Year) 2000

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

lar Freeman 515 Fairmont Ave Bathmore, MD 2/286 31. Data filed (Month, Day, Year)

State

32. Registrer's Signatura

DHMH 16 Rev 6/95

ORIGINAL

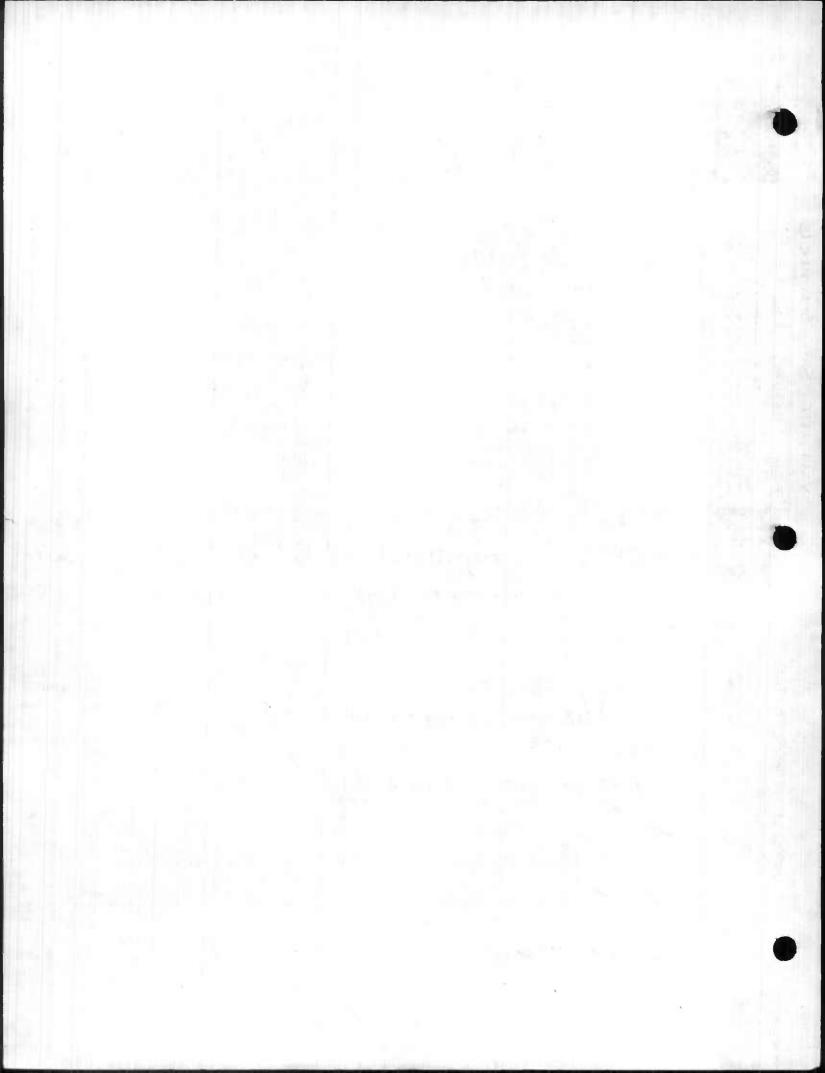
P.O. Box 68760, Records, of Vital

I or Attending Physician: after death. Director: After this certific

Division inby

To the Hospital of

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

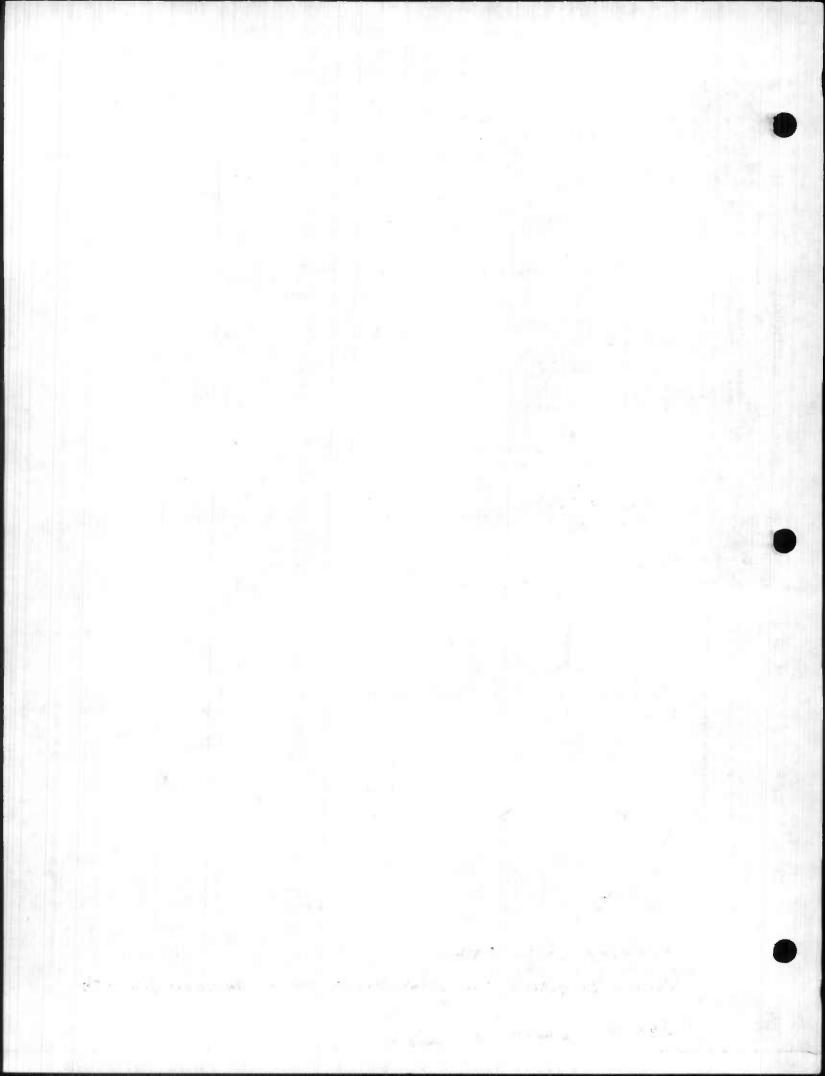
State of Maryland / Department of Health and Mental Hygiene 11 05494 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death FEBRUARY DO 20, 2000 **Physician** LENA MAF VECCHIONI 12:43pm /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) **Funeral** Days Months 1□M 2\ F 216-36-0811 59 Feb 20,1941 Director Maryland Usuel Residence of Decedent the Menyland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notined at 1 ☐ Yes 2X No Director MD Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7921 River Rock Way 21226 S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. should be filed within 72 hours after of Mental Hygiene.
marked other than "natural", or ite 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: À 3 ☐ Widowed 4 💆 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Postal Supervisor U.S. Postal Service 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Peges 1 and 2 should be filt ment of Heelth and Mental Hant: If item 27 is marked oth jury or other traumatic even Be William L. Long Clark Delores 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Angela Marie Todd-Daughter 7923 River Rock Way Baltimore, Maryland 21226 20b. Plece of Disposition (Name of cometery, cremetery or other plece)
Glen Haven
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete permit. Pege Department or Important: If any Injury or page. 2000 4 Donetion 5 Dother (Specify)ntombment Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Glen Burnie, Maryland 1 Second Avenue, S.W. the au 23a. Part 1. Enter the disease, or complications thei caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel ACUTE HEMMORHAGE 10 MINUTES disease or condition resulting in death) Examiner SMALL-CELL LUNG CANCER Examiner 6 MONTHS sician and burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Box 68760 Physician/Medical requires that the death certificate Due to (or as a consequence of): 88 USB signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 Yee 2 No 0 3 Probably 4 Unknown SPINAL CORD METASTASES Records. P 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? page 2 1 Yas 2 No Division of Vital Attending Physician: director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Anpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yes this 27. Manner of Deet 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation After TacNatural 2 Accident 1 Yes 2 No death. a Funeral Director: Jetaly filled in by the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 6 The Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **RES 000** FEBRUARY 20, 2000 MO 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) MIGO DOTHINA MD JOHNS HOPKING HOSE TAL BAYTHOLE, MD 21205 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar B. Sparke

ORIGINAL

DHMH 16 Rev 6/95

2 2000



Examiner physician and the burial-transit death. or Attend efter death Director:

Physician

/Medical

Examiner

10a. State

Directo

Funeral

P

Completed

Funeral

Director

item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at

12 should be filed within 72 hours after death on and Mental Hygiene. Is marked other than "natural", or itema 23.

permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 is n any Injury or other traur

Physician

/Medical

Examiner

Physician/Medical

p

Completed

Medical

Baltimore, Maryland 21215-0020

the Maryland

To the Vithin 2

Registrar

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Menner of Death 1 Netural 2 Accident 6 Could not be determined 28e. Pleca of injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es steted.

| Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner stated. 29a. Certifier (Check only one)

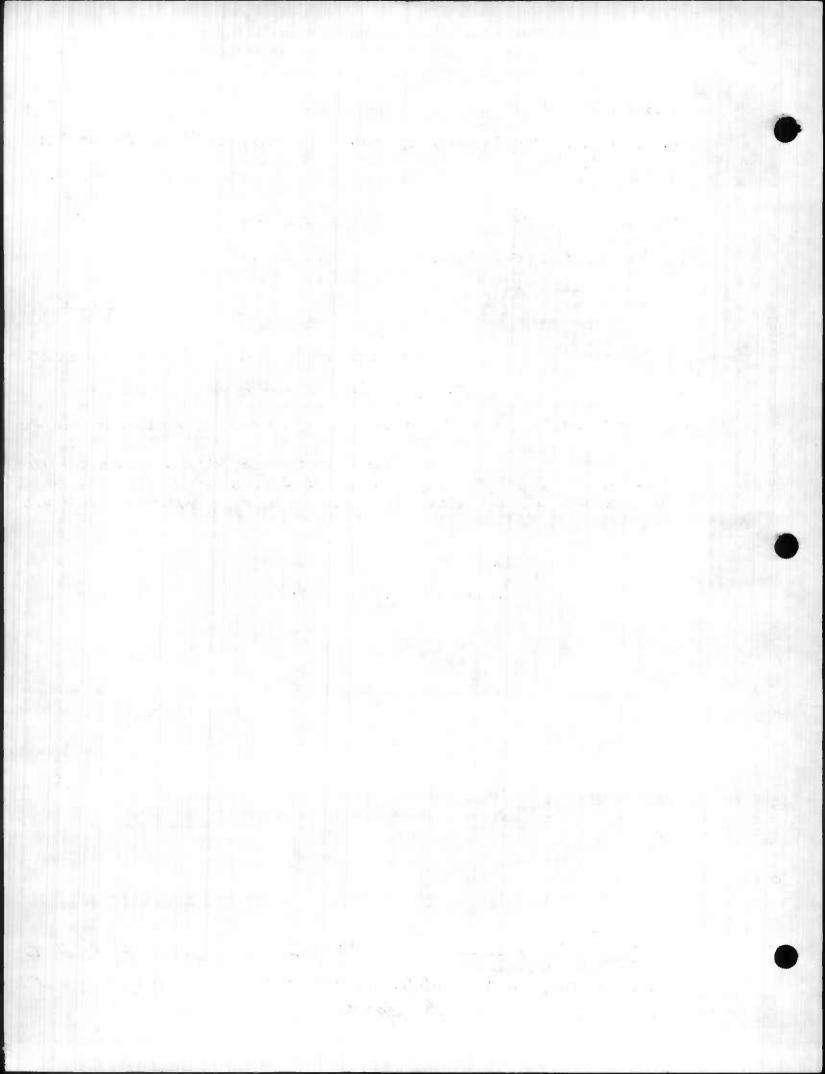
29c. License number 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

P14152

4611 Roland Ave Apt, #2 Hudson M.D.

32. Registrer's Signeture 31. Date filed (Month, Day, Year)



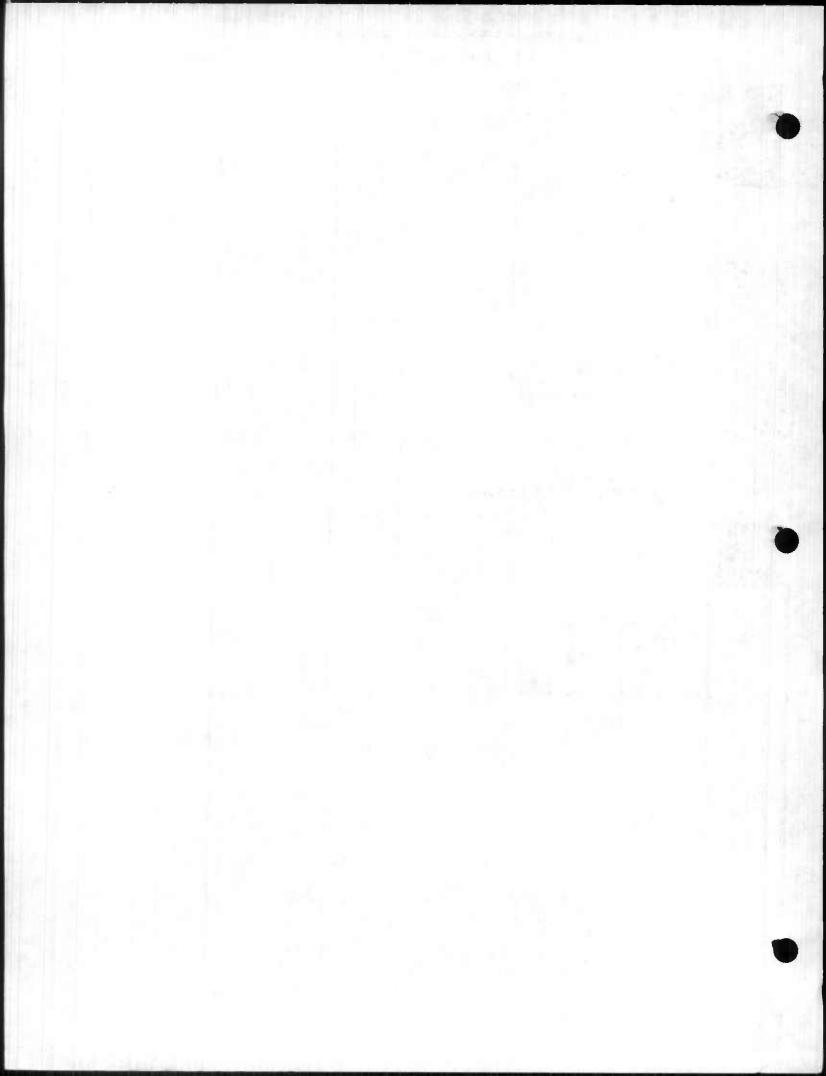
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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| - | 1. Decedent's Name (First, Middle, | Last) | | | | | 2. Date of D | | Vida | 3. Time of Dea | | |
| | ROSA FRANCES BU | ISH WETCATE | | | | | Month Februa | Day | . 2000 | 1:30 A | | |
| al - er | 4a Facility Name (If not institution, | | | | | 4b. City, Town, | or Location of Dea | | unty of Death | | | |
| 61 | | | | | | Timoni | | Dol. | rimoso | Country | | |
| | Stella Maris 5. Social Security Number | 6. Sex 7. Age | (In yrs. last birt | thday) | If Under 1 Year | Timoni If Under 24 H | | irth | | County | | |
| | | 1 □ M 2 Q(F | | Yrs. | Months Deys | Hours M | Irs. 8. Date of B (Month, D | | | place (State or Fo | | |
| | 213-16-0487 Usual Residence of Decedent | | 90 | | | | Sept | 17, 190 | 19 Ma | ryland | | |
| - | 10e. State 10b. County | f | 10c. City, Town | or Loca | tion | | | | | 10d. Inside City Li | | |
| ò | Marral and Dalain | ana Carmera | Timen | | | | | | | 1 ☐ Yas 2)X | | |
| | Maryland Baltimo | re county | Timon | Lum | 10f. Zip Code | | | 10a Citizen | of What Cou | intry? | | |
| | | -11 DI | | | | 0.2 | | | | , | | |
| runeral | 2300 Dulaney Va | 12. Was Decedent Ev | es la L1 C | 12 18/- | 210 | | (Conside Vac or N | 0 14 | USA Raca - Ameri | loen Indien | | |
| | 11. Marital Status | Armed Forces? | If Y | es, specify Cubi | an, Mexican, Pu | (Specify Yes or Nerto Rican, etc.) | | Black, White | | | | |
| | 1 ☐ Never Married 2 ☐ Merrie 3 ☑ Widowed 4 ☐ Divorced | If Yas, Give | Give ~ | | Yes 2∏ No | Specify: | | Spe | ecity: W | hite | | |
| | 21 | Year or Dates: | | | | | | 100 100 1 | f m . ' h | | | |
| 2 | 15. Decedent's (Specify only highest | grade completed) | 16a. | (Give kir. | nt's Usual Occup nd of work done | during most of a | working | 16b. Kind (| of Business/Ir | ndustry | | |
| Completed | 1 | Elementery/Secondery (0-12) | Coilege (1-4or 5+) | | life. DO | NOT use retired | 7) | | 1 | Retail | | |
| - | 7th | | R | esta | urant W | aitress | | Depar | rtment | Store | | |
| 1 | 17. Father's Name (First, Middle, Li | | | | | 18. Mother's h | Name (First, Middl | e, Maiden Sur | mame) | | | |
| 2 | Warren Kenneth | n Bush | | | | Margi | e C | arbaugl | 1 | | | |
| | 19a. Informant's Name/Relationshi | ip (Type, Print) | 19b. | . Mailing | Address (Street | and Number or | Rurel Route Num | ber, City or To | wn, State, Zi | ip Code) | | |
| | Alice F. Shaughr | ness (Daught | ter) 4 | 09 5 | ummit D | rives | Fallston | MD 2 | 1047 | | | |
| | 20e. Method of Disposition | | 20b. Plece of | Dispositi | ion (Name of tory or other place | | Date | 20c. Locati | ion - City or T | own, State | | |
| | 1 N Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe | | | | | | 10100100 | | | | | |
| - | 21. Signature of Funeral Services | - | Dulane | y Ve | alley Me | m Grdns | 2/22/20 | 00 Tim | onium, | Maryla | | |
| | Marky () | Toleuna. | | Mi | tchell- | Wiedefe | ld Funer | al Home | e. Inc | | | |
| | Martin D. La | awson | | | | | Baltimor | | , | 21212 | | |
| | 23a. Part1. Enter the disease, or c shock, or heart failure. List of | omplications that caused the | ne death. Do r | not enter | the mode of dyir | ng, such as care | diac or respiratory | errest, | | Approximate Interval Between | | |
| | | | | | | | | | 1 | Onset and Dea | | |
| | Immediate Cause (Final disease or condition | CORR | | | | | | | : | | | |
| | resulting in death) | a COPD | ue to (or as a o | ODEAGUE | ance of): | | | | 1 | | | |
| ē | | | 00 10 101 03 0 1 | 301130400 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | 1 | | | |
| Examiner | | b | ue to (or as a d | - Oneenue | ince of): | | | | 1 | | | |
| | if any, leading to immediate | | 0 (0 (0) 03 0 (| onisoque | mod ory. | | | | | | | |
| 5 | cause Enter Underlying | | | for se a consequence of: | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| Ē | that initiated events | C. Du | ue to (or as a c | onseque | nca of): | | | | | | | |
| 3 | that initiated events | d | ue to (or as a c | onseque | nca of): | | | | | | | |
| 3 | that initiated events | d | ue to (or as a c | conseque | nca of): | | | | | | | |
| ₹ | that initiated events | d | | | | ven in Part I. | 23b. Die | d tobacco use | a contributa | to the cause of | | |
| Physician/Medi | resulting in death) Last | d | | | | ven in Part I. | | d tobacco use | | | | |
| by Physician/M | resulting in death) Last | d | | | | ven in Part I. | 10 | Yaa 201 | No 3□Pro | obably 4 X Un | | |
| by Physician/M | resulting in death) Last | d | | | | ven in Part I. | 1 [24a. We | | No 3 Pro 24b. V | Obably 4 Un | | |
| by Physician/M | resulting in death) Last | d | | | | ven in Part I. | 1 [24a. We | Yaa 2 I | 24b. V | Vere autopsy find | | |
| Dy Pilysicialum | resulting in death) Last | d | | | | ven in Part I. | 24a. We | Yaa 2 I | No 3□Pro | Vere autopsy find vallable prior to completion of cau if death? | | |
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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Virginia Anne Weigert FEBRUARY 18 2000 12:30 A.M. 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs. BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 10 M 2X F Months Days Hours Min. 52 212-48-8674 August 11, 1947 Pennsylvania Usual Residence of Decedent 10e Stele 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 E. Joppa Road Apt. #1013 21286 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☒ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Apartment Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Weldon Sherwood Wertz, Sr. Mary Regina Flick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Goodwin 704 Murdock Road Baltimore, (sister) Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removel from State 2/19/00 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Oteva T. Fittle Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes ANO 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) STINO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Hatural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

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Physician

/Medical

Examiner

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Pages 1 and 2 should be named of Health and Mental

Important: If Item 27 any injury or other tr

Physician /Medical

72 hours after

Baltimore, Maryland 21215-0020

JOBRT,

Directo

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Completed

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Box 68760. P.O. Division of Vital Records. a Hospital or Attending Physician: 24 hours after death. a Funeral Director: After this certifical etaly filled in by the funeral director, I completely

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To the To the To the

State Registrar

31. Date filed (Month, Day, Year) FEB

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**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year) 600

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 'elans all

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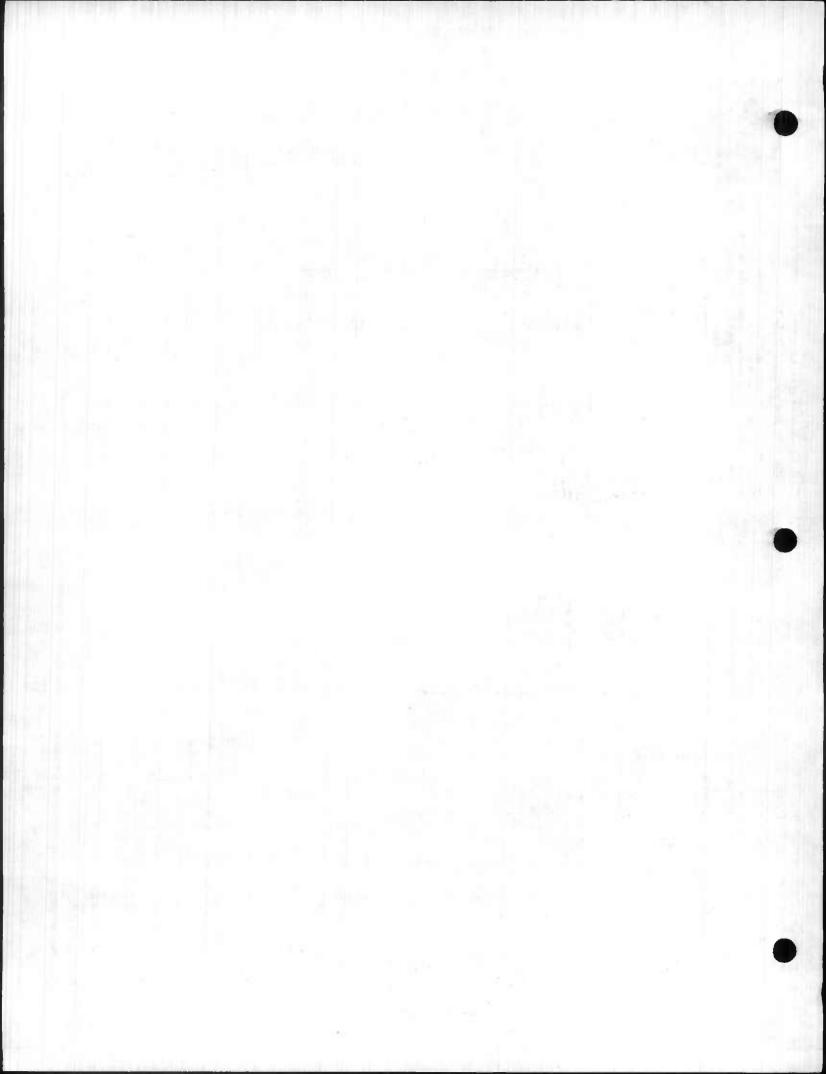
32. Registrar's Signature 2 2 2000

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29a. Certifier

(Check only one)

29b. Signature and title of certific

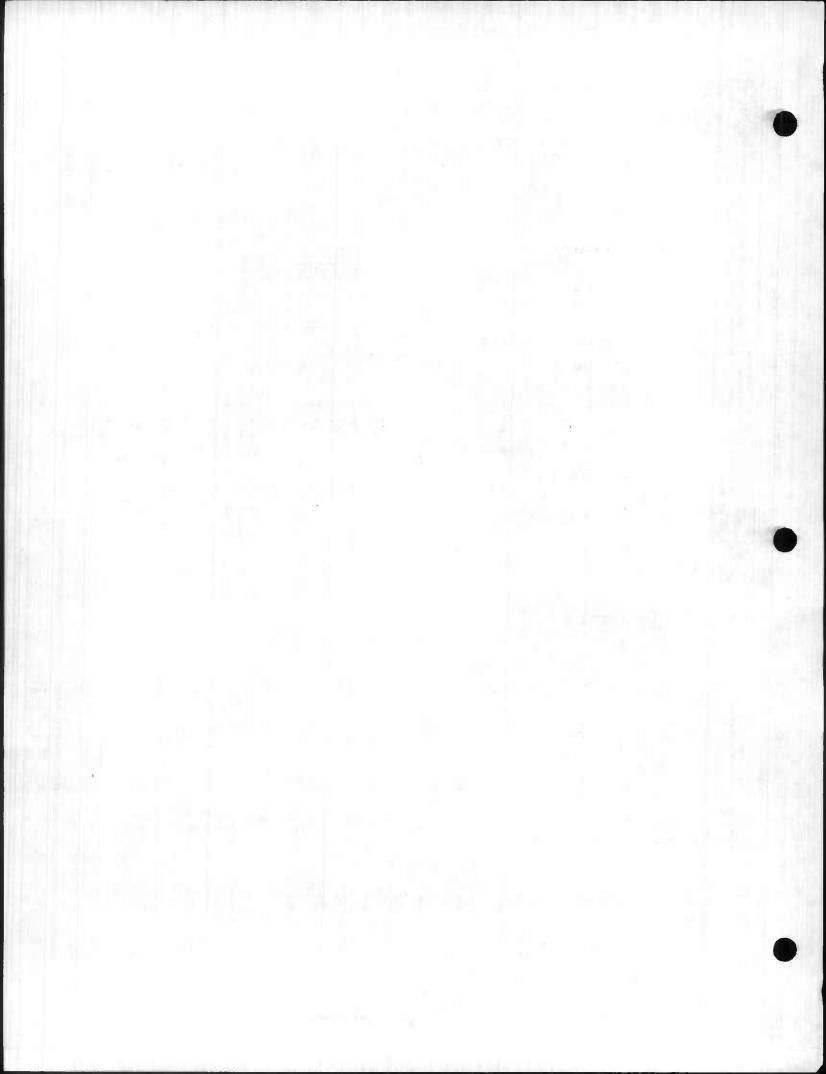


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert. Wade Feb 20 2000 8:10am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 105 Cowhide Circle Middle River Baltimore 8. Dete of Birth (Month, Day, Jan 2 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1€M 2□ F 220-14-3107 74 Jan Maryland Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director MD **Baltimore** Middle River 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 105 Cowhide Circle 21220 USA death v Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural", or fer any Injury or other traumatic event, the Medical Ensemble. ty Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plant Protection GM 12th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Albert L Wade Helen A Jackel 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Wade / wife 105 Cowhide Circle Baltimore Md. 21220 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Deta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stele 4 ☐ Donation 5 ☐ Other (Specify) 2/22/2000 Metro Crematory Inc. Baltimore Md. 21. Signature of Funerel Service Licensee 22. Neme and Address of Fecility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 23a. Part1. Enter the disease, or companion, or heart feilure. List on Approximata Interval Batween Onset and Deeth **Physician** /Medical Immediete Cause (Finat diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the Dua to (or as a consequance of): P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? page 2 1 Yas 1 Yes 2 No Division of Vital the Hospital or Attending Physicien: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? After 1 Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation I hours after death uneral Director: / 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 29a. Certifier t🕰 Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, date and place, and dua to the cause(s) snd manner as ststed. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred et the time, data end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) L 30. Name and address of person who completed co use of death (Item 23a) (Type, Print) 200

DHMH 16 Ray 6/95

State Registrar 32. Registrer's Signature



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State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month

Physician /Medical Examiner

Ronald Paul Weaver FEB 21 2000 8:00 PM 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 4212 Frederick Avenue Baltimore N/A If Under 24 Hrs. 8. Date of Birth
Hours | Min. (Month, Day, Ye If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F 214-38-6002 58 NOV 6, Director Pennsylvania Usuel Rasidence of Decedent death with the Maryland r 28a-f ahow inotified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 4212 Frederick Avenue 21229 Funeral USA 12. Wes Decedent Evar in U.S.
Amed Forces?

1 X Yes 2 No 1960/ Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: P 3 ☐ Widowed 4 ☒ Divorced Yeer or Dates: 1964 Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mass Transit 12 Mechanic/Storeroom Attendent Authority 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental I wit: If Item 27 is marked of Paul Stanley Weaver Beatrice Bowser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Raletionship (Type, Print) Jay A. Weaver/brother 1011 Cummings Ave. Baltimore, MD 21228 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, Stete Metro Crematory, Inc. 2/22/00 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 6 Department of important: If any injury or Baltimore, MD 4 Donation 5 Other (Specify) Cremation Society of Maryland, 21. Signature of Funerel Service Licensum Edward Gregorchik 299 Frederick Rd. Baltimore, MD Α. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth Physician tmmediate Cause (Final disease or condition resulting In deeth) /Medical yrs Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. tha Due to (or as a consequence of) for use as Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records, þ 2 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 E No certificate 1 ☐ Yas 2 ☐ No of Vital Attending Physician: director, 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home \$\infty \text{Residence} 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this. 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending Invastigation 1 Netural within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier To the 29b. Signature and tale of certific 29c. License number 29d. Date signed (Month, Day, Year) D30185 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rav 6/95

State

Registrar

R. Willer mo.

2000

31. Date filed (Month, Day, Year)

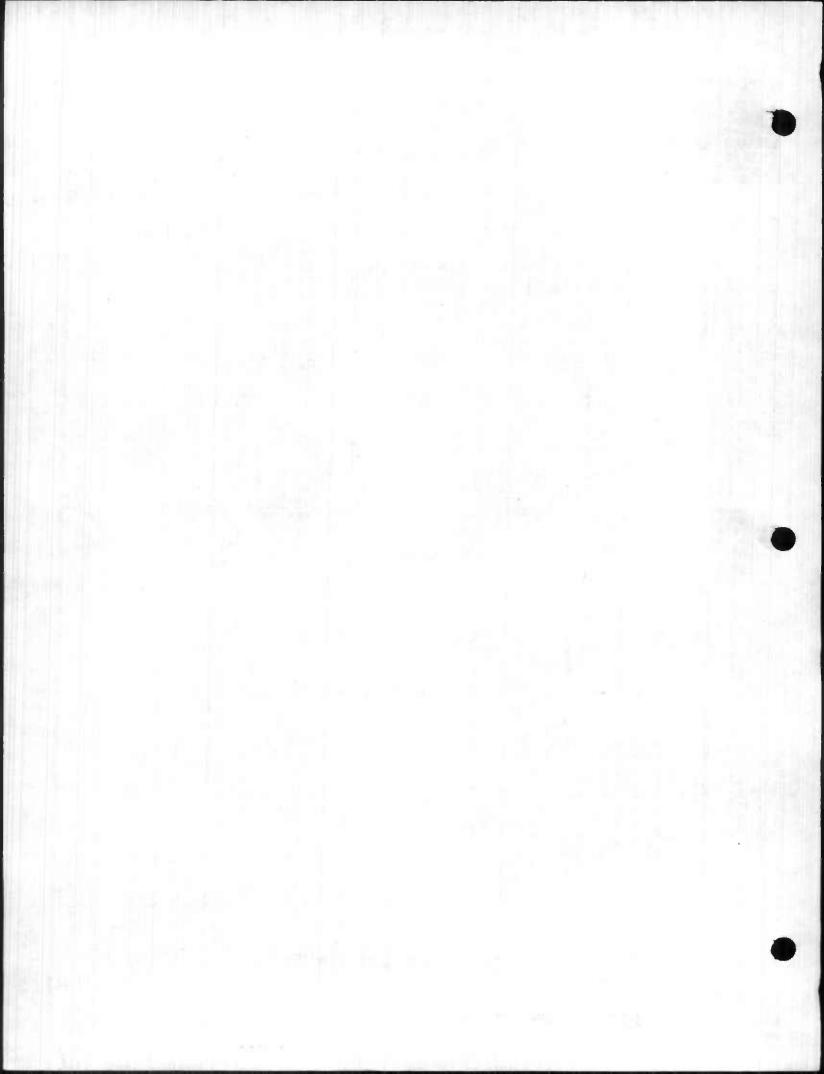
FEB 2

Frederic

32. Registrer's Signature

405

Rd. 5 110, Catons ville, Md. 21398



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Williams Daisy Feb. 16, 2000 cation of Death 4c. County of Death mm 05: 4 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore 7. Age (In yrs. last birthday) Manor are If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 10M 20 F Months Yrs. Director 218-07-1643 June 15,1917 Maryland Usual Residence of Deceden 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 212No Director Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 S. Hill Herna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) se filed within 7 sai Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Phone Company operator 12 permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked other any Injury or other traumetic avant ables. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ouis Williams Campbell athleen 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FISCher-Sister 1512 Putty Baltimoreimo Kathleen 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Feb. 19, 18 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryhod Druid Ridge Cemetery 2,000 22. Name and Address of Facility Lans Chapel of memories 21. Signature of Funeral Service Licensee leat Harford Rd. Baltimore, mp 21234 0088 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Marih Pummia Examiner Due to (or as a consequence of): Examiner 11'0 men physician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 3 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Marrner of Death
1. Natural
2. Accident 28d. Describe how injury occurred 4 hours after death.

*uneral Director: After the ely filled in by the funeral 28b. Time of 28c. Injury at Work? or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directornial of the Completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: Of the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of cumfies 29c. License number 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 105 Baltmore, mD21237 Fontana annama 31. Dete filed (Month, Dey, Year) 32. Pegistrar's Signeture State FEB 2 2 2000 Registrar

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